AMERICAN MEDICAL ASSOCIATION

HOUSE OF DELEGATES

BOSTON, JUNE 6, 1921

NOTICE: This Hand-Book is published for the information of members of the House of Delegates. The reports, as lished, are preliminary reports which are subject to ige. They are submitted in confidence to the Delegates will be official only after they, or some modification or titute for them, have been presented to the House of gates.

AMERICAN MEDICAL ASSOCIATION

HAND BOOK FOR THE HOUSE OF DELEGATES

General Officers, Standing and Special Committees, Members of the House, Official Order of Business, Reports for 1921 and Constitution and By-Laws and Standing Rules

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BOSTON, MASS.
JUNE 6-10, 1921

CONTENTS

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION, 1920-1921

GENERAL OFFICERS

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TREASURER

WILLIAM ALLEN PUSEY - - - - - - - - - - - CHICAGO

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DWIGHT H. MURRAY - - - - - - - - - SYRACUSE, N. Y.

VICE-SPEAKER, HOUSE OF DELEGATES

F. C. WARNSHUIS - - - - - - - - - GRAND RAPIDS, MICH.

EDITOR AND GENERAL MANAGER

GEORGE H. SIMMONS - - - - - - - - - - - CHICAGO

*Vice Isadore Dyer, Deceased.

BOARD OF TRUSTEES

TERM EXPIRES 1921

FRANK BILLINGS, Secretary - - - - - - - - - CHICAGO
WENDELL C. PHILLIPS - - - - - - - - - - New York
THOMAS MCDAVITT - - - - - - - - - - - ST. PAUL

TERM EXPIRES 1922

A. R. MITCHELL, Chairman - - - - - - - LINCOLN, NEB.
D. CHESTER BROWN - - - - - - - - - DANBURY, CONN.
OSCAR DOWLING - - - - - - - - - - SHREVEPORT, LA.

TERM EXPIRES 1923

CHARLES W. RICHARDSON - - - - - - WASHINGTON, D. C.
W. T. SARLES - - - - - - - - - - - - SPARTA, WIS.
WALTER T. WILLIAMSON - - - - - - - - PORTLAND, ORE.

STANDING COMMITTEES

JUDICIAL COUNCIL

Malcolm L. Harris, Chairman, Chicago, 1924
H. A. Black, Pueblo, Colo., 1921
Randolph Winslow, Baltimore, 1922
W. S. Thayer, Baltimore, 1923
I. C. Chase, Fort Worth, Texas, 1925
Alexander R. Craig, Chicago, Secretary

COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

Victor C. Vaughan, Chairman, Ann Arbor, Mich., 1921
Walter B. Cannon, Boston, 1922
W. S. Rankin, Raleigh, N. C., 1923
Haven Emerson, New York, 1924
Milton Board, Louisville, Ky., 1925
Frederick R. Green, Secretary, Chicago

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Arthur D. Bevan, Chairman, Chicago, 1923
W. D. Haggard, Nashville, Tenn., 1921
William Pepper, Philadelphia, 192
M. W. Ireland, U. S. Army *ad interim*
Ray L. Wilbur, Stanford University, Calif., 192'
N. P. Colwell, Secretary, Chicago

COUNCIL ON SCIENTIFIC ASSEMBLY

J. Shelton Horsley, Chairman, Richmond, Va., 1925
John E. Lane, New Haven, Conn., 1921
E. S. Judd, Rochester, Minn., 1
Roger S. Morris, Cincinnati, 1923
F. P. Gengenbach, Denver,
And ex-officio, the President-Elect, the Editor and Gener
Manager and the Secretary of the Association

COUNCIL ON PHARMACY AND CHEMISTRY

(Standing Committee of the Board of Trustees)

George H. Simmons, Chairman, Chicago, 1925

Reid Hunt, Boston, 1922

W. W. Palmer, Baltimore, 1922

Julius Stieglitz, Chicago, 1922

R. A. Hatcher, New York, 1923

A. W. Hewlett, San Francisco, 1923

W. T. Longcope, New York, 1923

John Howland, Baltimore, 1924

C. W. Edmunds, Ann Arbor, Mich., 1924

C. L. Alsberg, Washington, D. C., 1924

G. W. McCoy, Washington, D. C., 1925

F. G. Novy, Ann Arbor, Mich., 1925

L. G. Rowntree, Minneapolis, 1926

Torald Sollmann, Cleveland, 1926

Lafayette B. Mendel, New Haven, 1926

W. A. Puckner, Secretary, Chicago

NOTICE

The House of Delegates will meet at 10 a. m. on Monday, June 6, 1921, in the Boston Medical Library Building, 8 The Fenway, Boston.

The Committee on Credentials will meet in the hall adjoining the meeting place of the House of Delegates, at 9 a. m., on Monday, June 6, 1921. Credentials should be presented to the Committee as early as possible, so that the official roll of the House may be made up. The Committee on Credentials will also meet preceding each subsequent meeting of the House of Delegates.

Delegates should present properly executed credentials, signed by the president and secretary of the constituent association or section which they represent. Alternates presenting credentials should see that the delegates whose places they take have signed the alternate authorization.

Rooms adjoining the meeting place of the House of Delegates have been provided for the use of committees. The reference committees are urged to meet in these rooms and to announce the time of their meetings, that those interested in matters referred may be able to appear before the committees. Here will be found stenographers and typewriters who will be at the service of the members of the House of Delegates for preparing official reports and writing resolutions and motions.

In accordance with a resolution adopted by the House of Delegates at the Boston Session, 1906, all reports of committees, resolutions, written motions, etc., must be in duplicate, one copy for preservation in the minutes, and the other to go to the committee to which the matter is referred. Both copies should be handed to the Secretary at the time the matter is presented. Such copies can easily be secured by requesting the typewriter to make a carbon copy at the time the report is written.

MEETING PLACES AND HOTEL HEADQUARTERS

The following have been designated as section hotel headquarters, and as meeting places* for the Boston session—June 6 to 10:

HOUSE OF DELEGATES: *Boston Medical Library Building* (B).

GENERAL MEETING: *Boston Opera House.*

PRACTICE OF MEDICINE: Somerset (2). *Convention Hall* (D).

SURGERY, GENERAL AND ABDOMINAL: Lenox (4). *Jordan Hall* (E).

OBSTETRICS, GYNECOLOGY AND ABDOMINAL SURGERY: Buckminster (1). *Jordan Hall* (E).

OPHTHALMOLOGY: Vendome (6). *Huntington Hall* (C).

LARYNGOLOGY, OTOLOGY AND RHINOLOGY: Brunswick (12). *Huntington Hall* (C).

DISEASES OF CHILDREN: Parker House (School and Tremont Streets). *Convention Hall* (D).

PHARMACOLOGY AND THERAPEUTICS: Copley Square Hotel (7) *Harvard Medical School* (F).

PATHOLOGY AND PHYSIOLOGY: Bellevue (21 Beacon Street). *Harvard Medical School* (F).

STOMATOLOGY: Parker House (School and Tremont Streets). *Reception Hall, Mechanics Building* (A).

NERVOUS AND MENTAL DISEASES: Youngs Hotel (Court and City Hall Avenue). *Paul Revere Hall* (A).

DERMATOLOGY AND SYPHILOLOGY: Copley Square Hotel (7). *Talbot Hall* (A).

PREVENTIVE MEDICINE AND PUBLIC HEALTH: Bellevue (21 Beacon Street). *Harvard Medical School* (F).

UROLOGY: Westminster (11). *Talbot Hall* (A).

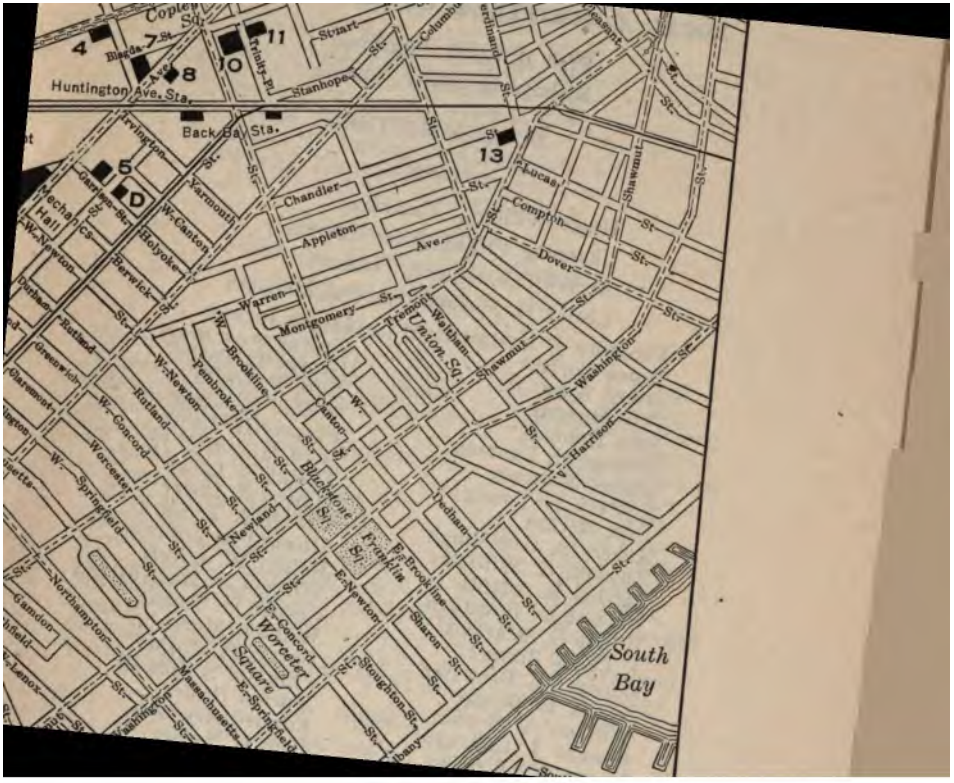
ORTHOPEDIC SURGERY: Adams House (553 Washington Street). *Paul Revere Hall* (A).

GASTRO-ENTEROLOGY AND PROCTOLOGY: Essex (693 Atlantic Avenue). *Harvard Medical School* (F).

MISCELLANEOUS (Meeting on Anesthesia): *Reception Hall, Mechanics Building* (A).

GENERAL HEADQUARTERS: SCIENTIFIC EXHIBIT, REGISTRATION BUREAU, COMMERCIAL EXHIBIT, INFORMATION BUREAU AND BRANCH POSTOFFICE: *Mechanics Building* (A).

* Meeting places in italics.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Back Bay Sta.
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Appleton
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Compton
Lucas
Shawmut
Union Sq.
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Warren
Montgomery
Washington
Harrison
Yarmouth
Holyoke
Berwick
Rutland
Brookline
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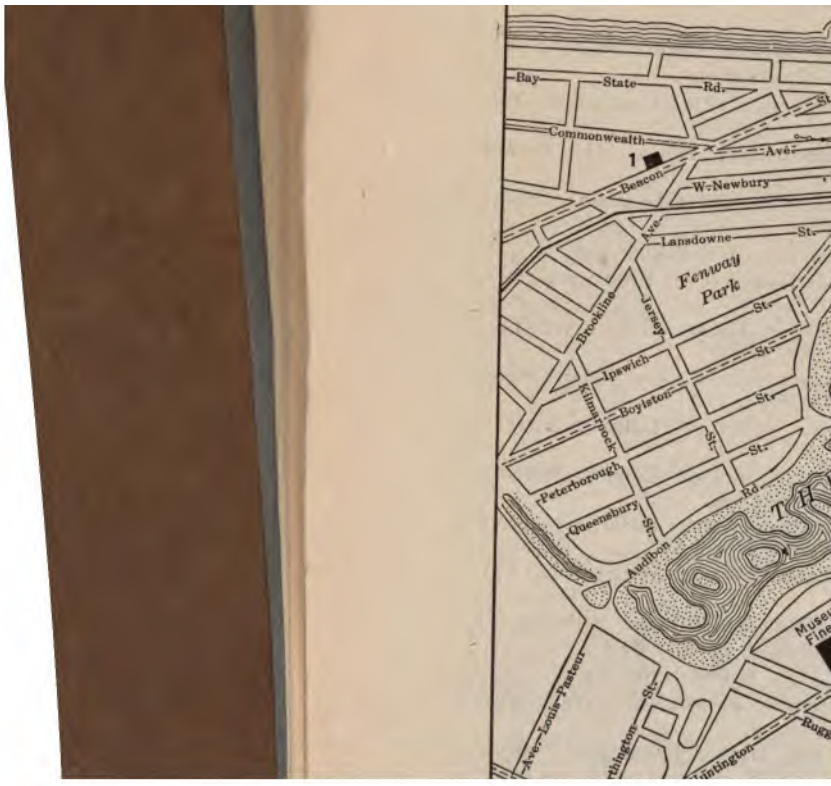
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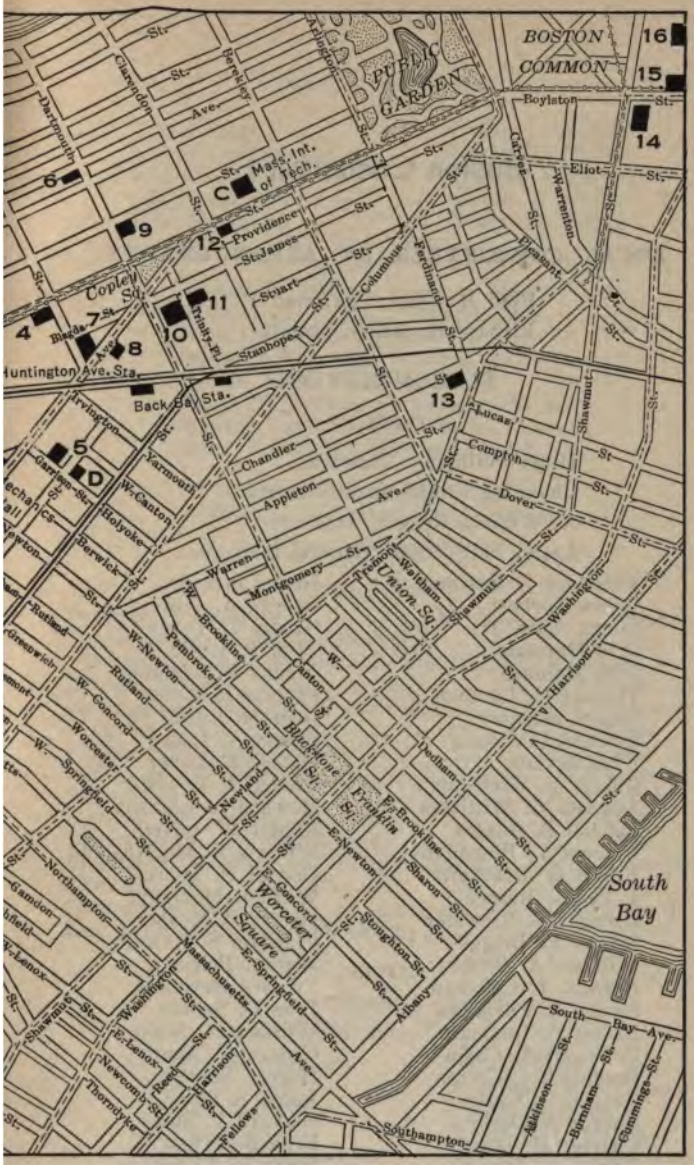
Ipswich
Kilmarnock
Boylston
Peterborough
Queensbury
Audubon
Rd.
Museum
Fine
Ave.
Louis Pasteur
Ruggles



4. Lenox.
5. Garrison Hall.
6. Vendome.
7. Copley Square Hotel.
8. Oxford.
9. Victoria.
10. Copley-Plaza.
11. Westminister.
12. Brunswick.
13. Arlington.

Boston Committees

LOCAL COMMITTEES OF ARRANGEMENTS

Fred B. Lund, Chairman
Richard H. Miller, Secretary

SUBCOMMITTEES

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Channing Frothingham, Secretary
A. William Reggio, Treasurer
Lesley H. Spooner, General Manager

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Lyman Allen, Burlington, Vt.
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Wilder Tileston, New Haven, Conn.
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Pharmacology and Therapeutics.....Reid Hunt
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Stomatology.....E. H. Smith
Nervous and Mental Diseases.....J. B. Ayer
Dermatology and Syphilology.....C. J. White
Preventive Medicine and Public Health.....M. J. Roseneau
Urology.....R. F. O'Neil
Orthopedic Surgery.....R. B. Osgood
Gastro-Enterology and Proctology.....F. W. White

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Malcolm Seymour
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Benjamin Tenney
Harold G. Tobey
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Benjamin E. Wood
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William E. Preble
Frank L. Richardson
David D. Scannell
Russell F. Sheldon
Warren R. Sisson
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Homer Gage
Alfred Worcester
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A. C. Nason
F. W. Anthony
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J. Arthur Gage
W. F. Sawyer

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J. L. Bremer
Percy Brown
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J. H. Cunningham
George Derby
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Harry W. Goodall
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J. B. Hawes
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Walter C. Howe
J. L. Huntington
J. P. O'Hare
Luther Paul
F. W. Peabody
Cadis Phipps
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E. P. Richardson
W. B. Robbins
M. H. Rogers
J. W. Sever
J. S. Stone
F. M. Spalding
E. C. Streeter
John B. Swift
Benjamin Tenney

A. R. Kimpton
John M. Little
E. A. Locke
Halsey Loder
D. F. Mahoney
L. G. Mead
George Minot
S. J. Mixter
Charles Mixter
W. R. Morrison (L.B.)
J. R. Torbert
John Warren
N. K. Wood
Wyman Whittemore
Roger I. Lee
Gerald Blake
Horace Packard
W. E. Ladd
Conrad Smith
W. H. Watters

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Philip D. Wilson, Secretary
G. Loring Tobey, Jr.
Fritz Irving

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John H. Cunningham, Chairman
L. S., Hapgood, Secretary

Excursion to Plymouth
Thomas Richards, Chairman

Golf
F. S. Newell, Chairman
G. L. Tobey, Jr., Secretary

Clubs
Henry Lyman, Chairman
Francis Rackemann, Secretary

Transportation
Lincoln Davis, Chairman
G. A. Leland, Jr., Secretary

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Mrs. C. A. Porter, Chairman
Mrs. Harvey Cushing
Mrs. Robert Lovett
Mrs. George Monks
Mrs. John T. Bottomley
Mrs. Conrad Wesselhoeft

Tea Committee
Mrs. Nathaniel Thayer, Chairman

Rest Rooms, Coat Rooms and Dressing Rooms
Mrs. E. A. Codman, Chairman

Information, Shopping and Theaters
Mrs. W. J. Mixter, Chairman

Excursions and Sightseeing
Mrs. F. B. Lund, Chairman

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John A. Foley

Telephones
Anna Richardson, Chairman

Aid Stations
Torr Wagner Harmer
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L. E. Phaneuf, Chairman

Information at South Station
Frank E. Haskins, Chairman

Information at Back Bay Station
A. K. Paine, Chairman

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Malcolm Storer

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James S. Stone

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J. D. Barney
F. A. Pemberton
Lyman Hapgood
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L. H. Spooner
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Cecil K. Drinker, Chairman

CLINICS

Joshua Hubbard, Chairman
Richard S. Eustis, Secretary

PRINTING

D. F. Jones, Chairman
George G. Smith, Secretary

COMMERCIAL EXHIBIT

W. H. Morrison, Chairman

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Florence W. Duckering
Sarah E. Palmer
Marion Nute
Eliza Cahill
Mary Leavitt
Edith H. Swift
Julia Tolman
Blanche A. Denig

Officers of Sections

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Chairman, Henry S. Plummer, Rochester, Minn.; Vice Chairman, G. Canby Robinson, Nashville, Tenn.; Secretary, Nellis B. Foster, New York. Executive Committee: Walter L. Bierring, Des Moines; James S. McLester, Birmingham, Ala.; H. S. Plummer, Rochester, Minn.

SURGERY, GENERAL AND ABDOMINAL

Chairman, George P. Muller, Philadelphia; Vice Chairman, E. Clarence Moore, Los Angeles; Secretary, Urban Maes, New Orleans. Executive Committee: John T. Bottomley, Boston; Dean D. Lewis, Chicago; George P. Muller, Philadelphia.

OBSTETRICS, GYNECOLOGGY AND ABDOMINAL SURGERY

Chairman, John O. Polak, Brooklyn; Vice Chairman, Lucius E. Burch, Nashville, Tenn.; Secretary, Sidney A. Chalfant, Pittsburgh. Executive Committee, Thomas J. Watkins, Chicago; Reuben Peterson, Ann Arbor, Mich.; John O. Polak, Brooklyn.

OPHTHALMOLOGY

Chairman, James Bordley, Jr., Baltimore; Vice Chairman, Marcus Feingold, New Orleans; Secretary, George S. Derby, Boston. Executive Committee, Cassius D. Westcott, Chicago; Allen Greenwood, Boston; James Bordley, Jr., Baltimore.

LARYNGOLOGY, OTOLOGY AND RHINOLOGY

Chairman, Ross H. Skillern, Philadelphia; Vice Chairman, Richmond McKinney, Memphis, Tenn.; Secretary, William B. Chamberlin, Cleveland. Executive Committee, Lee Wallace Dean, Iowa City; Joseph Beck, Chicago; Ross H. Skillern, Philadelphia.

DISEASES OF CHILDREN

Chairman, Frank C. Neff, Kansas City, Mo.; Vice Chairman, William Weston, Columbia, S. C.; Secretary, E. C. Fleischner, San Francisco. Executive Committee, Franklin P. Gengenbach, Denver; Fritz B. Talbot, Boston; Frank C. Neff, Kansas City, Mo.

PHARMACOLOGY AND THERAPEUTICS

Chairman, Leonard G. Rowntree, Rochester, Minn.; Vice Chairman, Carl Voegtlin, Washington, D. C.; Secretary, Cary Eggleston, New York. Executive Committee, Walter A. Bastedo, New York; George W. McCoy, Washington, D. C.; Leonard G. Rowntree, Rochester, Minn.

PATHOLOGY AND PHYSIOLOGY

Chairman, Edwin R. Le Count, Chicago; Vice Chairman, William S. Carter, Galveston, Texas; Secretary, Josiah J. Moore, Chicago. Executive Committee, Francis Carter Wood, New York; Howard T. Karsner, Cleveland; Edwin R. Le Count, Chicago.

STOMATOLOGY

Chairman, Henry S. Dunning, New York; Vice Chairman, Herbert A. Potts, Chicago; Secretary, Arthur D. Black, Chicago. Executive Committee, Eugene S. Talbot, Chicago; Vilray P. Blair, St. Louis; Henry S. Dunning, New York.

NERVOUS AND MENTAL DISEASES

Chairman, Arthur S. Hamilton, Minneapolis; Vice Chairman, Walter Timme, New York; Secretary, Charles W. Hitchcock, Detroit. Executive Committee, Charles Eugene Riggs, St. Paul; Archibald Church, Chicago; Arthur S. Hamilton, Minneapolis.

DERMATOLOGY AND SYPHILOLOGY

Chairman, Walter J. Highman, New York; Vice Chairman, Everett S. Lain, Oklahoma City; Secretary, Harold N. Cole, Cleveland. Executive Committee, Otto H. Foerster, Milwaukee; Oliver S. Ormsby, Chicago; Walter J. Highman, New York.

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Chairman, John D. McLean, Philadelphia; Vice Chairman, Clarence D. Selby, Toledo, Ohio; Secretary, Waller S. Leathers, University, Miss. Executive Committee, Clarence St. Claire Drake, Springfield, Ill.; James A. Hayne, Columbia, S. C.; John McLean, Philadelphia.

UROLOGY

Chairman, Richard F. O'Neil, Boston; Vice Chairman, Joseph Hume, New Orleans; Secretary, Herman L. Kretschmer, Chicago. Executive Committee, William F. Braasch, Rochester, Minn.; William E. Lower, Cleveland; Richard F. O'Neil, Boston.

ORTHOPEDIC SURGERY

Chairman, Melvin S. Henderson, Rochester, Minn.; Vice Chairman, H. Winnett Orr, Lincoln, Neb.; Secretary, Henry Bascom Thomas, Chicago. Executive Committee, Emil S. Geist, Minneapolis; George W. Hawley, New York; Melvin S. Henderson, Rochester, Minn.

GASTRO-ENTEROLOGY AND PROCTOLOGY

Chairman, Louis J. Hirschman, Detroit; Vice Chairman, H. W. Soper, St. Louis; Secretary, Franklin W. White, Boston. Executive Committee, William M. Beach, Pittsburgh; Frank Smithies, Chicago; Louis J. Hirschman, Detroit.

MISCELLANEOUS TOPICS

MEETING ON ANESTHESIA

Chairman, James T. Gwathmey, New York; Vice Chairman, Elmer I. McKesson, Toledo, Ohio; Secretary, F. Hoeffer McMechan, Avon Lake, Ohio.

House of Delegates, 1921

The following is a list of the holdover and newly elected members of the House of Delegates who have been reported in time to be included:

ALABAMA—3
F. W. Wilkerson.....Montgomery
S. W. Welch*.....Montgomery
J. D. Heacock*.....Birmingham

ARIZONA—1
D. F. Harbridge*.....Phoenix

ARKANSAS—2
George S. Brown.....Conway
William R. Bathurst*.....Little Rock

CAIFORNIA—3
H. Bert Ellis.....Los Angeles
Albert Soiland.....Los Angeles
John H. Graves.....San Francisco

COLORADO—2
Gerald B. Webb.....Colorado Springs
J. N. Hall*.....Denver

CONNECTICUT—2
John E. Lane.....New Haven
.....

DELAWARE—1
H. J. Stubbs*.....Wilmington

DISTRICT OF COLUMBIA—1
William Gerry Morgan.....Washington

FLORIDA—1
John S. Helms.....Tampa

GEORGIA—2
E. G. Jones.....Atlanta
W. C. Lyle*.....Atlanta

* Begin a new term with this session.

HAWAII—1

.....

IDAHO—1

.....

ILLINOIS—8

Charles J. Whalen ..... Chicago
G. Henry Mundt ..... Chicago
F. C. Sibley .....Carmi
T. O. Freeman .....Mattoon
J. W. Van Derslice*.....Oak Park
C. E. Humiston*.....Chicago
R. L. Green*.....Peoria
H. P. Beirne*.....Quincy

INDIANA—3

George W. Spohn .....Elkhart
Albert E. Bulson, Jr.....Fort Wayne
Joseph R. Eastman* .....Indianapolis

IOWA—3

L. W. Dean .....Iowa City
W. L. Allen .....Davenport
John C. Rockefellow*.....Des Moines

ISTHMIAN CANAL ZONE—1

Harry Eno ..... Christobal

KANSAS—3

Elmer E. Liggett .....Oswego
James W. May* .....Kansas City
C. Klippel* ..... Hutchinson

KENTUCKY—3

W. W. Richmond..... Clinton
John G. South*.....Frankfort
Lewis S. McMurtry*.....Louisville

LOUISIANA—2

L. R. DeBuys .....New Orleans
W. H. Seemann* .....New Orleans

MAINE—1

Bertram L. Bryant ..... Bangor

MARYLAND—2

Randolph Winslow ..... Baltimore
Thomas S. Cullen*.....Baltimore

MASSACHUSETTS—5

J. F. Burnham ..... Lawrence
H. G. Stetson ..... Greenfield
C. E. Mongan ..... Somerville
F. B. Lund* ..... Boston
E. F. Cody* ..... New Bedford

MICHIGAN—4

A. W. Hornbogen ..... Marquette
F. C. Warnshuis ..... Grand Rapids
Guy Connor ..... Detroit
J. B. Brook ..... Grandville

MINNESOTA—2

J. W. Bell ..... Minneapolis
W. H. Magie* ..... Duluth

MISSISSIPPI—1

J. W. Barksdale* ..... Winona

MISSOURI—5

Franklin E. Murphy ..... Kansas City
C. R. Woodson ..... St. Joseph
S. L. Baysinger ..... Rolla
.....
.....

MONTANA—1

E. W. Spottswood ..... Missoula

NEBRASKA—2

LeRoy Crumner ..... Omaha
W. O. Bridges* ..... Omaha

NEVADA—1

M. R. Walker ..... Reno

NEW HAMPSHIRE—1

D. E. Sullivan ..... Concord

NEW JERSEY—3

George E. Reading ..... Woodbury
H. H. Davis ..... Camden
Henry A. Cotton* ..... Trenton

NEW MEXICO—1

H. A. Miller* ..... Clovis

NEW YORK—11

R. Ellis Harris ..... New York
Eden V. Delphey ..... New York
Edward Livingston Hunt ..... New York
Arthur J. Berkell ..... Albany
J. Richard Kern ..... Brooklyn
Thomas C. Chalmers ..... Forest Hills
James P. Rooney* ..... Albany
Frederic P. Sanderson* ..... New York
William P. Campbell* ..... Brooklyn
George D. Meade* ..... Buffalo
Thomas H. Halsted* ..... Syracuse

NORTH CAROLINA—2

J. G. Myers ..... Charlotte
J. P. Highsmith* ..... Fayetteville

NORTH DAKOTA—1

P. A. Pray ..... Valley City

OHIO—6

J. H. J. Upham ..... Columbus
Ben R. McClellan ..... Xenia
C. D. Selby ..... Toledo
W. D. Haines ..... Cincinnati
George P. Pollansbee ..... Cleveland
Granville Warburton ..... Zanesville

OKLAHOMA—2

L. S. Willour ..... McAlester
L. J. Moorman* ..... Oklahoma City

OREGON—1

Joseph A. Pettit ..... Portland

PENNSYLVANIA—9

William P. Bacon ..... York
George R. S. Corson ..... Pottsville
Herbert B. Gibby ..... Wilkes-Barre
George G. Harman ..... Hutingdon
Wilmer Krusen ..... Philadelphia
C. A. E. Codman* ..... Philadelphia
John B. McAlister* ..... Harrisburg
George A. Knowles* ..... Philadelphia
John D. McLean* ..... Philadelphia

PHILIPPINE ISLANDS—1

Juan G. Mañagas ..... Baltimore

PORTO RICO—1
Jacinto Aviles ..... San Juan

RHODE ISLAND—1
Frederick T. Rogers ..... Providence

SOUTH CAROLINA—1
Edgar A. Hines* ..... Seneca

SOUTH DAKOTA—1
R. D. Alway ..... Aberdeen

TENNESSEE—2
E. T. Newell ..... Chattanooga
L. A. Yarbrough* ..... Covington

TEXAS—5
E. H. Cary ..... Dallas
J. Mark O'Farrell ..... Houston
.....
.....
.....

UTAH—1
S. G. Kahn* ..... Salt Lake City

VERMONT—1
Fred T. Kidder ..... Woodstock

VIRGINIA—3
Ennion G. Williams ..... Richmond
Southgate Leigh ..... Norfolk
.....

WASHINGTON—2
S. E. Lambert ..... Spokane
D. E. McGillivray* ..... Pt. Angeles

WEST VIRGINIA—2
Henry P. Linsz ..... Wheeling
James R. Bloss* ..... Huntington

WISCONSIN—3
Joseph F. Smith ..... Wausau
Rock Sleyster* ..... Wauwatosa
Horace M. Brown* ..... Milwaukee

WYOMING—1
George P. Johnston ..... Cheyenne

TUESDAY, JUNE 7—9:30 A. M.

1. Roll Call.
2. Reading and Adoption of Minutes.
3. Supplementary Report of Committee on Credentials.
4. Reports from Board of Trustees and the Councils.
5. Reports of Reference Committees:
   - (1) Reference Committee on Sections and Section Work.
   - (2) Reference Committee on Rules and Order of Business.
   - (3) Reference Committee on Medical Education.
   - (4) Reference Committee on Legislation and Political Action.
   - (5) Reference Committee on Hygiene and Sanitary Science.
   - (6) Reference Committee on Amendments to the Constitution and By-Laws.
   - (7) Reference Committee on Reports of Officers.
   - (8) Reference Committee on Miscellaneous Business.
6. Unfinished Business.
7. New Business. (See By-Laws, Chap. II, Sec. 2, p. 8.) (Wednesday meetings will be held subject to the action of the House of Delegates.)

THURSDAY, JUNE 9—2 P. M.*

1. Supplementary Report of Committee on Credentials.
2. Roll Call.
3. Reading and Adoption of Minutes.
4. Election of Officers:
   - (1) President.
   - (2) Vice President.
   - (3) Secretary.
   - (4) Treasurer.
   - (5) Speaker, House of Delegates.
   - (6) Vice Speaker, House of Delegates.

*See By-Laws, Chap. IV, Sec. 4, p. 10.

(7) Trustees.

Three to be elected to serve until 1924. The Trustees whose terms expire this year are: Frank Billings, Chicago; Wendell C. Phillips, New York; Thomas McDavitt, St. Paul. The other members of the Board of Trustees are: A. R. Mitchell, Lincoln, Neb., 1922; D. Chester Brown, Danbury, Conn., 1922; Oscar Dowling, Shreveport, La., 1922; W. T. Sarles, Sparta, Wis., 1923; Charles W. Richardson, Washington, D. C., 1923; Walter T. Williamson, Portland, Ore., 1923.

5. Nominations for Standing Committees by President, and Confirmation by the House of Delegates:

(1) Member of Judicial Council to succeed H. A. Black, Pueblo, Colo., for a term ending 1926. The other members of this Council are. Randolph Winslow, Baltimore, 1922; William S. Thayer, Baltimore, 1923; M. L. Harris, Chicago, 1924; I. C. Chase, Fort Worth, Texas, 1925.

(2) Member of Council on Health and Public Instruction, to succeed Victor C. Vaughan, Ann Arbor, Mich., for a term ending 1926. The other members of this Council are: W. B. Cannon, Boston, 1922; W. S. Rankin, Raleigh, N. C., 1923; Haven Emerison, New York, 1924; Milton Board, Louisville, Ky., 1925.

(3) Member of Council on Medical Education, to succeed W. D. Haggard, Nashville, Tenn., for a term ending 1926, and one to fill the vacancy occasioned by the death of Isadore Dyer, New Orleans (and filled by the *ad interim* appointment of M. W. Ireland, U. S. Army), for term ending 1924. The other members of this Council are: William Pepper, Philadelphia, 1922; Arthur D. Bevan, Chicago, 1923; Ray L. Wilbur, Stanford University, Calif., 1925.

(4) Member of Council on Scientific Assembly, to succeed John E. Lane, New Haven, Conn., for a term ending 1926. The other appointed members of this Council are: E. S. Judd, Rochester, Minn., 1922; Roger S. Morris, Cincinnati, 1923; F. P. Gengenbach, Denver, 1924; J. Shelton Horsley, Chairman, Richmond, Va., 1925.

6. Election of Honorary, Affiliate and Associate Fellows.
7. Selection of the Place and Fixing the Time for the 1922 Annual Session.
8. Supplementary Reports from Board of Trustees and Reference Committees.
9. Unfinished Business.
10. Adjournment.

Reports of Officers

SECRETARY'S REPORT

To the Members of the House of Delegates of the American Medical Association:

The following report is submitted for 1920-1921. It covers a period of thirteen months, from April 1, 1920, to May 1, 1921.

MEMBERSHIP

The membership of the several constituent associations which is the membership of this Association, according to records in the Secretary's office on May 1, 1921, was 84,971. This is shown in the accompanying table which also indicates the increase and the decrease in the membership of each of the organizations.

FELLOWSHIP

The Fellowship of the Scientific Assembly of the American Medical Association on April 1, 1920, was 47,045. During the thirteen months up to May 1, 1921, 554 Fellows have died, 1,215 have resigned, 308 have been dropped from the roll as not eligible, 347 have been dropped for non-payment of Fellowship dues and the names of sixty-two have been removed from the roll on account of being reported "not found," making a total of 2,486 names to be deducted from the Fellowship roll. Of these discontinuances, 543 have been transferred from the Fellowship roster to the subscription list of THE JOURNAL. There have been added to the Fellowship roll 6,411 names including 865 names of those who are new Fellows of the Scientific Assembly by virtue of their having been recently commissioned as medical officers on active duty in the several medical military departments of the federal government. Of the names newly entered on the Fellowship roll, 1,311 were transferred from the subscription list of the Association's publications. The Fellowship of the Association on May 1, 1921, was 50,970, a net increase for the thirteen months covered by this report of 3,925.

DEATHS OF OFFICERS

Dr. Isadore Dyer, vice president, died of heart disease at his home in New Orleans on October 12, 1920. At its meeting, held in November, the Board of Trustees elected Dr. Rudolph Matas, New Orleans, vice president to fill the unexpired term.

ORGANIZATION OF CONSTITUENT ASSOCIATIONS

Constituent Association of	No. Counties in State	No. Component Societies in State Assn.	Number Counties in State Not Organized		Physicians State (7th Ed. Directory)	Number Members of State Association		No. A. M. A. Fellows in State	No. Subscribers to Journal in State*
			1920	1921	No. in Ed.	1920	1921		
Alabama	67	67	.....	.....	2,405	1,728	1,683	500	353
Arizona	14	11	3	3	380	213	245	165	96
Arkansas	75	63	12	12	2,450	1,042	1,194	454	257
California	58	42	14	16	6,766	3,311	3,351	2,372	1,720
Colorado	63	36	34	27	1,817	950	896	598	391
Connecticut	8	8	.....	.....	1,729	1,054	1,019	658	445
Delaware	3	3	.....	.....	262	123	129	91	74
Dist. Columbia	.....	.....	.....	.....	1,689	567	567	375	303
Florida	54	31	22	23	1,281	572	577	305	286
Georgia	154	101	62	53	3,406	1,188	1,225	616	519
Idaho	44	26	25	18	553	184	250	128	135
Illinois	102	100	1	2	10,651	7,049	7,065	4,526	2,319
Indiana	92	90	1	2	4,446	2,331	2,420	1,337	624
Iowa	99	99	.....	.....	3,536	2,342	2,277	1,383	681
Kansas	105	67	38	38	2,550	1,760	1,639	864	414
Kentucky	120	114	2	6	3,323	2,353	2,142	730	373
Louisiana	64	41	24	23	2,001	1,203	1,124	853	316
Maine	16	15	1	1	1,105	712	667	324	182
Maryland[1]	23	21	2	2	2,364	1,143	1,274	843	701
Massachusetts[2]	14	14	.....	.....	5,959	3,840	3,798	2,435	1,387
Michigan	83	81	2	2	4,503	2,620	2,864	1,673	843
Minnesota	86	82	3	4	2,628	1,335	1,452	1,203	677
Mississippi	81	79	3	2	1,761	499	482	379	285
Missouri[1]	114	108	11	6	5,921	3,402	3,383	1,554	1,007
Montana	51	19	33	32	620	375	381	194	181
Nebraska	93	64	28	29	1,965	1,116	1,068	671	465
Nevada	17	3	13	14	147	73	91	55	35
New Hampshire	10	10	.....	.....	641	526	520	268	88
New Jersey	21	21	.....	.....	3,260	1,748	1,895	1,460	754
New Mexico	29	14	16	15	529	199	286	162	105
New York	62	61	.....	1	16,284	9,110	8,916	5,441	3,475
North Carolina	100	82	14	18	2,236	1,377	1,636	463	471
North Dakota	53	51	1	2	556	431	455	285	116
Ohio	88	87	1	1	8,092	4,670	4,556	2,502	1,469
Oklahoma	77	66	10	11	2,022	1,638	1,374	704	343
Oregon	36	34	3	2	1,145	707	616	286	327
Pennsylvania[3]	67	63	4	4	11,348	6,687	7,384	4,491	2,239
Rhode Island[2]	5	5	.....	.....	778	400	388	288	148
South Carolina	46	41	5	5	1,452	640	632	310	274
South Dakota[2]	68	10	8	8	658	385	398	247	174
Tennessee	96	67	29	29	3,328	1,612	1,743	721	390

ORGANIZATION OF CONSTITUENT ASSOCIATIONS—Continued

Constituent Association of	No. Counties in State	No. Component Societies in State Assn.	Number Counties in State Not Organized		No. Physicians in State (7th Ed. Directory)	Number Members of State Association		No. A. M. A. Fellows in State	No. Subscribers to Journal in State*
			1920	1921		1920	1921		
Texas	248	179	70	69	6,205	3,102	3,606	1,816	899
Utah	29	5	25	24	496	266	296	183	135
Vermont	14	12	2	2	594	406	379	168	96
Virginia[4]	100	65	41	35	2,545	1,735	1,898	642	446
Washington	39	19	20	20	1,797	1,096	987	598	442
West Virginia	55	41	12	14	1,717	1,078	1,235	512	432
Wisconsin	71	70	.....	1	2,750	1,904	1,949	1,125	705
Wyoming	22	10	17	12	267	92	130	82	86
Misc., Foreign, Govt. sub. for Army, Navy & U. S. P. H. S.	.....	.....	.....	.....	.....	.....	.....	139	2,936
Canal Zone	.....	.....	.....	.....	.....	102	74	21	24
Hawaii	5	.....	.....	.....	.....	72	81	38	48
Porto Rico	7	.....	.....	.....	.....	126	116	24	39
Philippine Isl.	.....	.....	.....	.....	.....	144	158	56	88
Totals	3,048	2,398	612	588	145,608	83,338	84,971	48,318	31,768
Commissioned Officers[5] and Honorary Fellows								2,652	
								50,970	

* Not including Fellows of American Medical Association.

Note.—The number of members of the different associations stated in this table is in accord with the membership of the several associations as they were reported to the Secretary on April 1, 1921.

The lack of an effective uniform system for reporting the membership of the state associations accounts for whatever discrepancies this table shows and detracts from the value of the statement.

Component societies are those societies which compose the state association. A component society may include one county or more.

1. The state of Maryland has 23 counties and the city of Baltimore; Missouri has 114 counties and the city of St. Louis.
2. These state associations are divided into district societies, and these are listed in the table as component societies. Some of these districts are smaller and some larger than the county, the county lines being ignored.
3. Provision is made for the physicians in each of these counties to join the component society in an adjoining county.
4. Virginia has recently adopted the plan of organization and is now establishing component county medical societies.
5. This figure includes the Medical Corps of the Army, the Navy and the Public Health Service.

Doctor Dyer at the time of his death was also a member of the Council on Medical Education and Hospitals. Surg.-Gen. Merritte W. Ireland was appointed, *ad interim*, by the President to fill the vacancy.

ORGANIZATION

The world war and conditions which have developed subsequently have affected the American Medical Association very much in the same manner as other organizations. Attention has been called to certain specific instances in my previous reports to the House of Delegates. The social and economic unrest still prevails but there seems to be developing gradually a more stable condition of affairs.

The reaction from the altruistic and patriotic motives which controlled actions during the war has had its influence on the esteem in which some physicians hold the principles which have always been the basis of the policies of this Association. One of the dangers which merits the consideration of the House of Delegates is the apparent tendency on the part of certain physicians and a few component county societies to be dominated by commercial ideals rather than by the standards which the Association has adopted in formulating its Principles of Medical Ethics. The opening statement of these principles is: "A profession has for its prime object the service it can render to humanity. Reward or financial gain should be a subordinate consideration." This subject is presented to the House of Delegates because, as representatives of the organized medical profession, the members of this House are in a position to carry back to the constituent associations and through these to the component societies influences which shall correct these destructive tendencies.

During the war and since, a number of the component county societies have been inactive. In each instance, when the office of the Secretary of the Association has been informed that a county society was not holding meetings, the secretary of the constituent state or territorial association, of which the society was a branch, has been written to and urged to have steps taken to revive active work in such component societies. The state organizations have responded to these suggestions so that those branches, which were inactive, are again functioning in a more effective manner.

Again, in certain localities, there have been evidences of a lack of coordinated action and failure to appreciate the essential unity of all branches of the organization. While it is recognized that each constituent association is an entity and is competent to act for itself, it is essential that the component societies in each state shall actually be federated and shall cooperate with each other in carrying on the work of the organized profession, first within the county and then

within the state. The same principle must hold in the relationship which exists between the constituent associations and the national body. The best work can be accomplished only when an undivided, loyal cooperation exists between all branches of the organization, the county society acting for the physicians within its jurisdiction and transmitting to the constituent association of which it is a part memorials on subjects in which the cooperation of the other component societies of the state is desired, and the state associations in turn acting to coordinate the work of its component societies and transmitting to the House of Delegates of the American Medical Association memorials presenting subjects for the consideration of this House of Delegates. Such procedure would in no wise interfere with this House of Delegates initiating action on a motion submitted directly by one of its members.

One of the most effective measures for carrying out the purposes of the organized medical profession is the education both of its members and of the lay public regarding questions relating to the health and physical welfare of the community. When action has been taken without first gaining the support of public opinion in the community, it is not unusual for failure to result. Occasionally either branches of the organization or their officers have endeavored to put into effect measures which, to the uninformed layman, seem to be primarily in the interests of practitioners of medicine. This has permitted those whose personal interests are affected to make a specious claim to the general public that they are being persecuted by members of the medical profession. This cry of persecution is an effective appeal, especially when it is presented in the form in which it is usually made by those who in fact are exploiting the people. If the members of this House of Delegates will urge the organizations which they represent to be active in informing the influential citizens of their several communities regarding matters which affect the preservation of health and the treatment of disease, the result undoubtedly will be that the people themselves will appreciate more fully the value of laws regulating health conditions and controlling the practice of the healing art so that the public rather than the medical profession alone will demand these laws and will require their enforcement.

MEMORIALS AND OPINIONS

The By-Laws of the Association provide that no memorial, resolution or opinion of any character whatever shall be

issued in the name of the American Medical Association unless it has been approved by the House of Delegates. This places on the House a grave responsibility in formulating the policies of the Association. From time to time, moot scientific questions have been brought to the attention of the House of Delegates. It is a serious matter to commit the Association on such questions when the problems have to be determined in the time available during an annual session; and under the present arrangements there is no standing committee to which the House of Delegates may refer such questions for deliberation and a report recommending action. If the House deems it wise, provision might be made so as to make it the function of one of the existing Councils—the Council on Scientific Assembly is suggested because of its relationship to the Scientific Assembly—to investigate such of these scientific questions as the House of Delegates may refer to it, and to report back recommendations for action. The By-Laws empower a Council to appoint special committees subject to the approval of the Board of Trustees for purposes falling within the jurisdiction of the Council. Consequently, the Council which has this subject within its jurisdiction is in a position to create a special committee or a bureau to carry out the necessary inquiries or studies. As suggested, such a bureau or committee, sitting with the Council on Scientific Assembly either at the annual session or in the *interim*, could give careful consideration to questions involving a scientific opinion so that the House of Delegates might be thoroughly informed before it takes action.

Additional matters in which the office of the Secretary has been active are reported to the House of Delegates through other channels.

Respectfully submitted,

ALEXANDER R. CRAIG, Secretary.

REPORT OF THE BOARD OF TRUSTEES

To the Members of the House of Delegates of the American Medical Association:

The year 1920 will be referred to in the future as the year of high prices, of abnormal profits in nearly every line of business, and of an hysterical condition in which all economic laws were treated as though they were nonexistent. In our publication department we were affected by the abnormally high scale of wages and the high cost of paper and of all other materials that go into the conduct of a printing establishment. On the other hand, we were faced with the fact that while the cost of every article purchased was steadily increasing, that which we had to sell—THE JOURNAL—was remaining stationary so far as the Fellowship and subscription departments were concerned.

In our report last year it was stated that "the steadily increasing cost of production is likely to cause serious concern if it continues much longer," specific reference being made to the increased cost of paper during the year 1919 and to the fact that wages in the printing trade had been advancing. It was then added:

> While there is no immediate cause for anxiety, it is well for us to realize that we must be prepared for whatever the future may have in store. It may be necessary either to increase the subscription price of THE JOURNAL—say $1 a year—or to reduce its size. However, this is for the future. Your attention is called to these matters that you may know the conditions that have developed and which are developing.

You know what transpired, viz., it finally became necessary either that THE JOURNAL should be published at a serious loss or that there should be an increase in the subscription and Fellowship dues. As you have before you the minutes of the special session of the House of Delegates called last November, to raise the annual dues, it is unnecessary to do more than refer you to these minutes.

An analysis of the conditions of the year shows that during the first two months—that is, before the first increase in the cost of labor and paper during the year (1920) went into effect—the profits on the publication were quite satisfactory

—this not only because of the increase in circulation but also, and especially, on account of the unusually satisfactory returns from the Advertising Department. To a less extent the same applies to the following four months, when the cost of paper took a second upward turn. From that time on, to about August, when the labor scale made another large increase and the price of paper again advanced, we were just about running even. From August on we were operating at a loss. However, the profits of the first half of the year were sufficient to more than carry the loss of the latter half, so that, as will be noticed by the Auditor's Report, we were able to show a net gain for the year of a little over $30,000.

The present outlook as to the cost of production is uncertain. In February there was a decrease in the cost of paper stock, approximately equivalent to the last increase—in September, 1920. But thus far the high scale for labor continues.

ADVERTISING DEPARTMENT

For the fairly satisfactory financial outcome for the year, considerable credit must be given to the Advertising Department. As you probably are aware, until toward the end of the year 1920 there was a very large amount of advertising of all descriptions in all kinds of periodicals. The reason is well known—the income tax. Toward the end of the year, and still more since the first of the present year, there has been a most decided falling off—the excess advertising to which we refer has vanished. These comments apply to periodicals in general but apparently not to THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, for thus far our advertising is keeping up. The enormous circulation of THE JOURNAL and the standard of the men whom it reaches make it an advertising medium of great value to those who want to reach the leading members of our profession. It is needless to say that our advertising standard is still kept up, and, if anything, the advertising committee is more exacting.

It may be of interest to note that the receipts from dues and subscriptions exceeded those from advertising until the year 1919, when this order was reversed. In 1919 the receipts from advertising were $395,598; whereas the receipts from dues and subscriptions were $357,684. Last year the receipts from advertising were $512,765, and from dues and subscriptions $386,825.

SUBSCRIPTION DEPARTMENT

In the addenda to this report will be found, in tabular form, the facts regarding circulation. The number of names on the mailing list—i. e., bona fide subscribers, including Fellows—on Jan. 1, 1920, was 74,919; on Jan. 1, 1921, 78,560—a gain for the year of 3,641. The total number of copies printed during 1920 was 4,110,112—349,761 more than in 1919. The weekly average was 79,040—an increase in the average of 6,726 over 1919. This must be regarded as satisfactory. Since the first of January of this current year there has not been an issue printed of less than 80,000 copies.

SPANISH EDITION

The circulation of the Spanish Edition of THE JOURNAL is slowly increasing; the number of bona fide paid subscribers on January 1 this year was 3,611, as against 2,908 a year ago. The circulation covers pretty nearly all Spanish-speaking countries; naturally, the largest circulation is in Mexico—approximately 600. Cuba comes next with 500 copies; then Argentina, 403; Brazil, 312; Philippine Islands, 254; Spain, 236, and Chile, 232. The rest is scattered in the various Spanish-speaking countries.

The monetary exchange condition is a serious handicap not only in securing remittances but also in promoting circulation. This accounts in part for the loss, which amounts to about $9,000. We may naturally expect that conditions will improve, otherwise the Board would have to consider whether the good to be obtained is worth the cost. There is no doubt that the publication of this journal is doing much good: it is bringing the Association, as well as American medicine, prominently and most favorably to the attention of the best physicians in the Pan-American countries, Mexico, the Philippines, etc.; it is surely developing a friendly spirit; it is bringing to this country, as students and for postgraduate work, many who otherwise would be going to European countries. It will be remembered that the Rockefeller Foundation bears half the loss.

SPECIAL JOURNALS

All our special journals are doing well so far as circulation is concerned; there was a financial loss, however, during the year on all except the ARCHIVES OF INTERNAL MEDICINE.

The circulation of the AMERICAN JOURNAL OF DISEASES OF CHILDREN is steadily increasing; it numbered 2,911 on the first of this year, as compared with 2,531 on Jan. 1, 1920.

The circulation of the ARCHIVES OF INTERNAL MEDICINE is improving, although the increase last year was only 198, making the total circulation on the first of this year 2,791.

The circulation of the ARCHIVES OF NEUROLOGY AND PSYCHIATRY was 1,248 on Jan. 1, 1921, as compared with 1,158 the preceding year—not as large as that of either of the above mentioned journals, as the specialty it represents is limited in number. However, the circulation is steadily increasing.

The ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY has now been published by the Association one year and, we are informed, is highly appreciated by dermatologists of the country. Its circulation, too, naturally is limited—1,051 on January 1. It, too, is steadily growing.

The publication of the ARCHIVES OF SURGERY was begun in July, as a bimonthly, and numbers were issued in July, September and November. The circulation during the year 1920 reached 3,273.

As we have stated, there were losses on all these special publications, with the exception of the ARCHIVES OF INTERNAL MEDICINE. These losses are accounted for by the radical increase in the cost of production in every branch of the printing trade, and especially in the price of paper. We did not have to contend with the unstabilized paper market so far as paper for THE JOURNAL and the Spanish Edition was concerned: with paper for our special journals it was different; it was not possible to contract for the year's supply of this paper, hence we were compelled to meet the market conditions as they developed. The result was that we had to pay whatever the market demanded. We are better prepared for the future, since we have been able to make a contract similar to that for THE JOURNAL, the terms of which will give us paper for these special journals 50 per cent. less then it cost us last year.

Under the conditions that had developed, the Board felt it wise to discontinue the combination rates on the special journals, and in some instances to increase the price. Naturally, therefore, a better showing may be looked for this year. For instance: 1,863 of the subscribers to the ARCHIVES OF INTERNAL MEDICINE. by clubbing paid only $4 a year; hereafter they will pay the regular $5 rate. The 2,187 subscribers to the AMERICAN JOURNAL OF DISEASES OF CHILDREN who were paying the combination rate of $3 will this year pay $4. The price of the ARCHIVES OF NEUROLOGY AND PSYCHIATRY and of the ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY has been

increased from $5 to $6, and since many of the subscribers to these periodicals were paying only $4 under the combination rate, there will be quite an increase in the receipts under the new order. It is believed that these increases will make these journals at least self-supporting. However, it is well to bear in mind that even if it should be necessary to increase the subscription price of these journals, say, another $1 or $2, they would still be far cheaper than similar special journals published elsewhere. May we again emphasize that one of the great opportunities for the advancement of scientific medicine in the United States is the encouragement of these special journals? While we should not publish them at a loss, they should be issued at as near cost as possible. The Association, with its splendid printing facilities and its direct contact with the profession of the whole country, is able to do this work better and cheaper than it is possible for the men interested in these specialties to have their journals printed and published elsewhere, and to promote their circulation at a nominal expense. When our building is completed our printing plant will be capable of taking on more of these publications.

QUARTERLY CUMULATIVE MEDICAL INDEX

Related to the special journals, and published ultimately for the same reason—that is, for the advancement of scientific medicine in the United States—is the Quarterly Cumulative Medical Index. This index is heartily appreciated by research workers and by those physicians who are attempting to keep up with medical progress; it is regarded by such men as one of the most helpful publications on medical literature in any language. The circulation is steadily creeping up: at the end of the year 1920 there were 1,045 bona fide subscribers, as against 738 the preceding year. Incidentally, the increase during the first part of the current year is greater than that during the same period last year.

COOPERATIVE MEDICAL ADVERTISING BUREAU

The Bureau closed its seventh year, Dec. 1, 1920. The financial reports show it has been increasingly helpful to the state journals each year. During 1920, it did a gross total business of 65,976.91; and after paying all expenses distributed to the twenty-eight state journals, on a pro rata basis, excess earnings of $3,500. This amount was in the nature of

a bonus, as each journal had been paid its earnings regularly each month, as they came due.

In addition to securing general advertising for the state journals, the Cooperative Bureau, as its name implies, helps to coordinate the work of these publications. It provides the publishers with information about general advertisers, keeps them informed about credits and business conditions, answers inquiries regarding acceptable advertising, and in other ways renders the individual publishers a real service, without charge.

Prior to the organization of the Bureau, the advantages of the state journals as advertising mediums were imperfectly understood. But the Bureau has continuously advertised them until general advertisers have begun to appreciate their worth and are now including these journals in their lists of publicity mediums. This service feature is appreciated by both publishers and advertisers. The latter have come to understand that this chain of twenty-eight state journals comprises a list of reliable, standardized publications, which can be handled through the Bureau in one order. This method is a distinct advantage to both advertisers and publishers. The state journal editors have shown increasing confidence in the Bureau, as it has demonstrated its ability to secure advertising accounts which individual publishers could not obtain. All of the state-owned medical journals, except the Illinois, are now represented by the Bureau.

BUILDING

In its report to you two years ago, at Atlantic City, the Board of Trustees stated that the increased activities were beginning to crowd the Association headquarters, especially in the printing department; and that it was proposed to tear down the old building and extend the main one to take in this space. This, it was stated, would give a steel and concrete structure 100 by 120 feet, six stories and a high basement, of sufficient strength to make possible the addition of two, three or even four more stories if future needs require additional room. Other facts also were given at that time regarding the proposition. Later the architects were authorized to draw preliminary plans and to make estimate of the cost. This was done and presented to the Board in October. The tentative plans were accepted, and the architects were authorized to proceed to make complete plans and detailed specifications. These detailed plans and specifica-

tions were presented to and approved by the Board at its meeting in February, 1920. The estimated cost was $280,000. The architects were then instructed to call for bids. In due time the bids came in, the lowest of which was $420,000 and it had strings to it. The Board therefore decided to postpone building. As more room had become absolutely necessary, the lease on three floors of the old building was terminated, and this space is now being used. But this is a makeshift arrangement and should be terminated as soon as building conditions warrant.

Prices of building material seem to be coming down, and we are informed that the cost today would quite probably come very near to the architects' original estimate. The outlook certainly is more promising than in the past, and we hope it may soon be such that the Board will feel justified in authorizing construction of the building. From the present outlook there will be sufficient funds to complete the building without going into debt; this would not have been the case last year. There is one serious feature: the present depreciated prices of securities. While all of the Association's bonds are high-class, few will bring the original cost. Even the government bonds, in which the Association has invested $175,000, probably would have to be sold at a sacrifice. Of course your Board of Trustees will give careful consideration to the matter before finally deciding to go ahead. When this building is completed it will be possible for the Association to undertake additional work in the interest of the profession and public health which your Board has not heretofore felt inclined to recommend on account of the expense.

COMMITTEE ON REHABILITATION OF EX-SERVICE MEN

Early in March the Committee on Hospitalization of ex-service men of the American Legion, through Dr. Billings, requested a conference with representatives of the American Medical Association attending the Congress on Medical Education and Hospitals, Licensure and Public Health, then being held in Chicago, with the object of securing cooperation of the American Medical Association looking to the improvement of the unsatisfactory condition of affairs in the hospitalization and care of disabled ex-service men. The conference was held in Chicago on March 7, at which were present: Gen. Abel Davis, Major A. A. Sprague and Dr. Thomas B. V. Keene, members of the National Committee on Hospitalization and Rehabilitation of the American Legion; Surgeon-

General Cumming and Drs. Lavender and McDill, of the United States Public Health Service; Dr. Thomas W. Salmon, representing the National Committee for Mental Hygiene, and Dr. Charles J. Hatfield, representing the National Tuberculosis Association. The American Medical Association was represented by President-elect Work; Drs. A. R. Mitchell, W. T. Sarles and Frank Billings, representing the Board of Trustees; Drs. A. R. Craig, George H. Simmons, E. E. Irons, J. N. McCormack, Ray Lyman Wilbur and others. After the conference the matter was taken up by the Executive Committee of the Board of Trustees, which at that time was holding its regular monthly meeting in Chicago. It called into conference President Braisted, President-elect Work, Surgeon-General Ireland, Dr. J. N. McCormack, Dr. George H. Simmons and Dr. A. R. Craig. As a result of this conference, President Braisted appointed the following committee to act in the matter: Dr. Frank Billings (chairman), Dr. Hubert Work and Dr. J. N. McCormack. It was the understanding that this committee should go to Washington, investigate and advise with the committees of the American Legion and others. The matter was submitted to the full Board by vote and approved. The committee then proceeded to Washington, accompanied, at its request, by the editor and general manager, who worked with the committee. On March 17 and 18 the committee held conferences in Washington with the Surgeon-General of the Public Health Service, with officers of the Bureau of War Risk Insurance and with others, making a preliminary and general survey of the whole subject.

Meantime, Dr. Billings had been selected by the Secretary of the Treasury as a member of a board of consultants on hospitalization of ex-service men. It was, therefore, decided by the committee that inasmuch as Dr. Billings was a member of an official government committee, he could represent the committee of the American Medical Association unofficially but effectively. Hence, while the Association's committee has not been discharged, it has ceased active work awaiting further developments.

A report of the result of the activities of our committee and other committees was published in THE JOURNAL, April 16, p. 1112.

DIRECTORY

The Seventh Edition of the Directory was issued in April. The delay in its publication was the result, in part, of the

difficulty in securing clerical assistants in the early stages of the revision and, in part also, of the unusual number of changes—removals. The Directory Department estimates that the removals amounted to approximately 30 per cent. This not only added to the amount of work, but also took more time, as it was difficult to locate many who had moved. The unusual number of removals undoubtedly was the result of the war; evidently many physicians who gave up their practice and went into the army made use of the opportunity to change their locations on returning to civil practice.

The advance orders for this edition nearly double those for the former edition—4,200 for the Sixth, as compared with approximately 8,000 for the Seventh. Nine thousand copies were printed, as compared with 6,000 copies of the previous edition.

We can make no statement at the time this is written regarding the financial side.

THE PROPAGANDA DEPARTMENT

The Propaganda Department continues to be a clearing house for information relative to the nostrum evil and quackery. Many of you no doubt imagine that the only information disseminated by this department is that which appears in the pages of THE JOURNAL devoted to it. Yet, as a matter of fact, this is but a small part of its work. Letters of inquiry that run into the thousands are annually received and answered by the department. About as many of these inquiries come from the public as from members of our profession. There is an increasing number of letters from students in schools and colleges, owing to the fact that the work of the Propaganda Department has come to be recognized to an extent that it is referred to in school and college textbooks. Moreover, teachers of home economics, civic biology, hygiene, etc., devote a certain amount of time to the study of the nostrum evil, and the Association's work along this line is, naturally, brought out. The past year has brought a large number of letters of inquiry relative to nostrums of the alcoholic type and also a large number from those who are interested in the problem of medical advertising copy in newspapers and magazines. Advertising managers and agencies, secretaries of advertising clubs, and especially officials of the Associated Advertising Clubs of the World, are in regular correspondence with the department. The influence that the department is exerting in the interest of truthfulness and honesty in medical matters

as they affect the public directly will never be generally known; but to those who are familiar with the facts, this feature of the department's work is especially encouraging and impressive. An active demand continues for the pamphlets, books, educational posters and stereopticon slides prepared and issued by the department. New editions of the pamphlets prepared by the department are continually being issued. The same is true of the educational posters on the nostrum evil; these are reprinted from time to time with modification and additions that bring them down to date, while a certain number of new posters are prepared each year. The new edition of "Nostrums and Quackery" has, through shortage of help and the urgency of other work, been delayed, but it is now practically ready for distribution.

COUNCIL ON PHARMACY AND CHEMISTRY

The Council on Pharmacy and Chemistry is continuing the splendid work which has put the profession of this country far ahead of that of any other, in that it is protected against misrepresentation and commercialism inherent in the exploitation of proprietary medicines. The fact that this country is better off in this regard than others is obvious to those who will compare the advertisements of medical products in even the highest-class medical journals of Europe, including Great Britain, with those of this country. While there are still many medical journals in this country that do not follow the Council, with two or three exceptions its influence for good on these journals is apparent. Excluding that mentioned above, all the state journals refuse to carry medicinal products not accepted by the Council. One sometimes wonders whether our profession really appreciates what this body of scientific men has done, and is still doing, for the medical profession and the public, and for the advancement of scientific and rational therapy. It is well known that a certain percentage do appreciate this, but it is feared that the percentage is not as large as it should, and would, be if physicians were more familiar with this work. That much has been accomplished will be appreciated if one compares conditions of twenty years ago and now.

The problems of the Council today are radically different from those which existed when it was first organized. In the early days they were, to a large extent, concerned with the secret and semisecret complex mixtures of simple drugs exploited to our profession under fanciful names and with

extravagant claims. These have been forced into obscurity, and physicians who still prescribe them are reticent about it. However, in the place of these ancient nostrums we now have biologic products, and biologic therapy is tending toward conditions just as serious as those which resulted from the exploitation of the shotgun drug mixtures; and they are more dangerous. What promised to be a blessing seems to be proving a menace. In any event we must be on our guard against the present commercial exploitation of this form of therapy. The point is, these preparations are being exploited through our profession directly, and to the public indirectly, for financial gain rather than in the interest of scientific medicine and for the good of the public. Another development in therapeutics somewhat related to the field of biologic therapy is the intravenous use not only of biologic products but also of drugs and chemicals—a method of treatment which has numerous dangers. These newer problems which are engaging the attention of the Council should also concern every physician.

New and Nonofficial Remedies is the official publication of the Council, issued annually. This book contains a list of the proprietary products accepted by the Council, and physicians may protect themselves by having this book available for reference when they desire information on unofficial and proprietary preparations.

Useful Drugs and the Epitome of the Pharmacopeia also are published under the supervision of the Council. They are used in quantities by medical students and by teachers in medical schools.

The Council has a Committee on Therapeutic Research, for which the Trustees make an appropriation each year. This appropriation is used for investigations and laboratory research into the actions of drugs and pharmaceutical products. The results are published in various medical journals and are included each year in a single publication, "A. M. A. Therapeutic Research Reports."

Detailed reports of the activities of the Council on Medical Education and Hospitals, the Council on Health and Public Instruction and the Judicial Council will be submitted directly by these bodies; hence it is not necessary to refer here to the work of the Association carried on by these councils.

As an addenda we submit, in addition to the facts covering the circulation of THE JOURNAL, etc., the Treasurer's statement, and the official and complete Auditor's report.

COMMITTEE ON SCIENTIFIC RESEARCH

As the Board previously reported to you, a Committee on Scientific Research was constituted in 1900 and continued until 1914 when, in the curtailment of expenses, it was found necessary to discontinue making an annual appropriation for its work. In 1918 the Board felt justified in reestablishing this grant, and appropriated $1,200; in 1919 a similar appropriation was made; in 1920, $1,500; and this year, $1,500. The object of these grants, of course, is to further meritorious research in subjects relating to scientific medicine and of practical interest to the medical profession, special effort being made to aid such work as otherwise might not be carried on to completion. We are of the firm opinion that this expenditure is well worth while. Before long it is hoped to publish a complete list of all the grants since the first appropriation, made in 1903.

Respectfully submitted,

A. R. MITCHELL, Chairman,
FRANK BILLINGS, Secretary,
D. CHESTER BROWN,
OSCAR DOWLING,
THOMAS MCDAVITT,
WENDELL C. PHILLIPS,
CHARLES W. RICHARDSON,
W. T. SARLES,
WALTER T. WILLIAMSON.

ADDENDA TO TRUSTEES' REPORT

SUBSCRIPTION DEPARTMENT

The regular weekly issue of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, from Jan. 1, 1920, to Dec. 31, 1920, inclusive (52 issues), was as follows:

January 3	76,250		July 3	78,080	
January 10	76,379		July 10	78,036	
January 17	75,471		July 17	77,667	
January 24	75,686		July 24	78,050	
January 31	75,577		July 31	78,226	
		379,363			390,059
February 7	75,976		August 7	79,047	
February 14	76,135		August 14	79,400	
February 21	76,042		August 21	79,196	
February 28	76,531		August 28	79,512	
		304,684			317,155
March 6	76,003		September 4	79,675	
March 13	76,326		September 11	79,412	
March 20	80,548		September 18	79,717	
March 27	76,494		September 25	80,092	
		309,371			318,896
			October 2	80,003	
April 3	76,650		October 9	79,954	
April 10	76,518		October 16	80,188	
April 17	76,470		October 23	80,433	
April 24	76,664		October 30	80,655	
		306,302			401,233
May 1	76,636				
May 8	77,826		November 6	80,166	
May 15	81,798		November 13	80,679	
May 22	77,382		November 20	80,878	
May 29	77,638		November 27	94,538	
		391,280			336,261
June 5	78,159		December 4	95,530	
June 12	78,004		December 11	85,226	
June 19	77,875		December 18	81,113	
June 26	78,245		December 25	81,356	
		312,283			343,225

Total 4,110,112

Weekly average 79,040

PERCENTAGE OF PHYSICIANS RECEIVING THE JOURNAL

This table gives the number of physicians (based on the sixth edition of the American Medical Directory) in the United States, the number receiving THE JOURNAL, and the approximate percentage in each state. Copies to physicians in the United States Army, United States Navy, Public Health Service, etc., are not included.

State	Number Receiving JOURNAL	Physicians in State 6th A. M. Dir.	Approx. Percentage 6th A. M. Dir.
Alabama	854	2,530	34
Arizona	260	333	78
Arkansas	710	2,587	27
California	3,829	5,929	65
Colorado	964	1,713	57
Connecticut	1,095	1,701	64
Delaware	124	264	47
District of Columbia	654	1,237	53
Florida	573	1,296	44
Georgia	1,126	3,442	33
Idaho	244	458	53
Illinois	6,688	11,095	60
Indiana	1,933	4,765	40
Iowa	2,013	4,004	50
Kansas	1,261	2,668	47
Kentucky	1,075	3,483	31
Louisiana	1,166	2,060	56
Maine	496	1,179	42
Maryland	1,452	2,268	64
Massachusetts	3,740	5,926	63
Michigan	2,443	4,598	53
Minnesota	1,824	2,566	71
Mississippi	643	1,975	33
Missouri	2,473	6,063	41
Montana	356	661	54
Nebraska	1,103	1,960	57
Nevada	93	159	59
New Hampshire	348	666	52
New Jersey	1,184	3,153	69
New Mexico	250	456	55
New York	8,628	15,877	54
North Carolina	932	2,257	41
North Dakota	379	604	63
Ohio	3,866	8,089	48
Oklahoma	1,003	2,672	37
Oregon	597	1,157	52
Pennsylvania	6,635	11,495	58
Rhode Island	438	752	58
South Carolina	583	1,433	41
South Dakota	424	695	61
Tennessee	1,086	3,481	31
Texas	2,637	6,246	42
Utah	305	488	62
Vermont	254	653	38
Virginia	1,066	2,552	42
Washington	1,008	1,698	54
West Virginia	905	1,759	52
Wisconsin	1,759	2,817	62
Wyoming	162	254	63

The following table shows the number of Fellows and subscribers on THE JOURNAL mailing list, for each year, commencing with 1900, omitting advertisers, exchanges, libraries, colleges, etc.:

Year	Fellows	Subscribers
January 1st, 1900	8,445	4,633
January 1st, 1901	9,841	8,339
January 1st, 1902	11,107	10,795
January 1st, 1903	12,553	12,378
January 1st, 1904	13,899	14,674
January 1st, 1905	17,570	15,698
January 1st, 1906	20,826	17,669
January 1st, 1907	26,255	20,166
January 1st, 1908	29,382	20,880
January 1st, 1909	31,999	18,983
January 1st, 1910	33,032	19,832
January 1st, 1911	33,540	20,504
January 1st, 1912	33,250	21,620
January 1st, 1913	36,082	19,863
January 1st, 1914	39,518	19,751
January 1st, 1915	41,254	20,430
January 1st, 1916	41,938	22,921
January 1st, 1917	42,744	22,156
January 1st, 1918	43,420	23,117
January 1st, 1919	42,366	24,687
January 1st, 1920	44,340	30,032
January 1st, 1921	46,669	31,347

The total number of transfers to Fellowship was 3,914 in 1920.

The total number of copies printed during the past year (3,760,351) was 265,504 more than were printed the previous year.

TREASURER'S REPORT

Report of the Treasurer of the American Medical Association for the year ended December 31, 1920

ASSOCIATION RESERVE FUND

Reserve Fund as at December 31, 1919		$283,186.42
Interest—Bonds	$12,067.72	
Interest—Uninvested	300.27	
		12,367.99
Reserve Fund as at December 31, 1920		$295,554.41

TREASURER'S GENERAL ACCOUNT

Balance as at December 31, 1920	$ 265.34

DAVIS MEMORIAL FUND

Balance as at December 31, 1919		$ 3,762.16
Interest		87.19
		$ 3,849.35
Disbursements:		
Invested in U. S. 4¼'s Gov. Bonds	$ 3,701.60	
Accrued Interest	6.65	
Northern Trust Co.—Rebate	0.47	
Care of Bonds	1.84	
		$ 3,710.56
Balance uninvested as at December 31, 1920		138.79

SUMMARY AS AT DECEMBER 31, 1920

Invested in Bonds	$ 3,701.60	
Cash Balance	138.79	
		$ 3,840.39

AUDITOR'S REPORT

CHICAGO, January 18, 1921.

To the Board of Trustees,
American Medical Association, Chicago, Illinois.

Dear Sirs:

In accordance with your instructions, we have audited the accounts of the American Medical Association for the year ended December 31, 1920, and now submit our report thereon.

SURPLUS ACCOUNT

The surplus at the beginning of the year amounted to $456,839.39, and the surplus at the end of the year amounted to $489,694.97, an increase of $32,855.58. This increase is spread over the assets and liabilities as follows:

Increase in Current and Working Assets		$ 5,612.55
Increase in Prepaid Expenses		55,027.60
		$ 60,640.15
Less:		
Decrease in Fixed Assets	$11,628.56	
Increase in Accounts Payable	13,905.70	
Increase in Advance Payments on Publications	2,250.31	
		$ 27,784.57
Net Increase in Surplus, as above		$ 32,855 58

FINANCIAL POSITION

The financial position of the Association as at December 31, 1920, is shown in the following statement:

BALANCE SHEET AS AT DEC. 31, 1920

ASSETS:			
Property and Equipment at Cost, less Depreciation:			
Real Estate and Buildings			$201,534.40
Machinery			43,779.97
Type and Metals			6,902.51
Furniture and Equipment			15,730.93
Chemical Laboratory			1,537.43
Library			736.15
			$270,221.39
Reserve Fund Investment			295,554.41
Current and Working Assets:			
Inventory of Materials, Supplies and Work in Process		$ 99,280.74	
Accounts Receivable:			
Advertising	$54,244.80		
Cooperative Medical Advertising Bureau	7,360.48		
Reprints	2,577.63		
Miscellaneous	13,423.10		
		$77,606.01	
Notes Receivable		1,884.03	
Cash in Bank and on Hand		16,086.99	
			$194,857,77
Prepaid Expenses:			
Insurance		$ 982.78	
Session 1921		1,327.82	
Directory, Seventh Edition		53,621.50	
			$ 55,932.10
Total			$816,565.67
LIABILITIES:			
Accounts Payable:			
Cooperative Medical Advertising Bureau		$ 5,527.25	
Sundry		15,227.55	
			$ 20,754.80
Advance Payments on Publications			10,561.49
Association Reserve Fund			295,554.41
Surplus			489,694.97
Total			$816,565.67

The balance sheet submitted, in our opinion, correctly reflects the financial position of the Association as at December 31, 1920, subject to provision for accrued interest, taxes and "Journal" subscriptions paid in advance, less subscriptions and memberships due and unpaid.

We examined the securities representing the investment of the Association Reserve Fund, and found them in order.

We verified the cash on hand by actual count and the cash in bank by certificates obtained from the Association's bankers. The following is a statement of the cash balances:

Continental and Commercial National Bank	$ 15,270.66
First Trust and Savings Bank (Treasurer's Account)	265.34
Cash on Hand	400.99
Cashier's Fund	150.00
Total	$ 16,086.99

OPERATIONS

The operations of the Association for the year ended December 31, 1920, are shown in the following statements:

INCOME AND PROFIT AND LOSS ACCOUNT FOR THE YEAR ENDED DECEMBER 31, 1920

JOURNAL:		
INCOME:		
Fellowship Dues and Subscriptions		$386,825.21
Advertising		512,765.71
Jobbing		16,643.35
Books		8,228.29
Reprints		5,937.14
Insignia		2,335.92
Miscellaneous Sales		16,828.39
Interest		5,096.82
		$954,660.83
Expenses, Schedule "1"		791,665.03
Net Income from Journal		$162,995.80
MISCELLANEOUS INCOME:		
Cooperative Medical Advertising Bureau	$ 209.16	
Directory, Sixth Edition	1,440.02	
Archives of Internal Medicine	388.46	
Rent	3,740.00	
Miscellaneous	271.10	
		$ 6,048.74
		$169,044.54
Association Expenses—Schedule "2"	$85,203.59	
Less (Session) 1920	923.50	
	$84,280.09	
Miscellaneous Expenses—Schedule "3"	51,908.87	
		$136,188.96
Net Gain on Operations		$ 32,855.58

JOURNAL EXPENSES—SCHEDULE "1"

Wages and Salaries	$288,411.45
Editorials, News and Reporting	8,655.48
Paper—Journal Stock	298,358.66
Paper—Miscellaneous	16,427.95
Electrotypes	16,352.17
Binding	449.25
Ink	7,487.36
Postage—First Class	19,957.02
Postage—Second Class	38,080.22
Journal Commissions	8,338.91
Collection Commissions	848.07
Discounts	18,121.89
Express and Cartage	3,466.44
Exchange	3,893.05
Office Supplies	2,136.07
Telephone and Telegraph	1,306.76
Office Jobbing	6,088.81

Miscellaneous	14,577.09
Power and Light	3,951.76
Fuel	4,629.93
Factory Supplies	11,827.14
Repairs and Renewals—Machinery	5,167.53
Bad Debts, Net Loss	1,022.13
	$779.555.14

Depreciation:

Property and Equipment	Rate	Amount	
Machinery	15%	$7,725.87	
Furniture and Equipment	15%	1,952.55	
Factory Equipment	15%	705.84	
Type	20%	777.37	
Metal	20%	948.26	
			$ 12,109.89
Total			$791,665.03

ASSOCIATION EXPENSES—SCHEDULE "2"

Association	$ 28,649.19
Health and Public Instruction	11,739.31
Pharmacy and Chemistry and Chemical Laboratory	21,766.78
Medical Education and Hospitals	17,523.11
Organization	3,531.74
Therapeutic Research	1,822.63
Laboratory Depreciation—10%	170.83
Total	$ 85,203.59

MISCELLANEOUS EXPENSES—SCHEDULE "3"

Building "B" (New), Depreciation 5%	$ 7,575.28
Building Improvements	6,000.00
Insurance and Taxes	8,031.65
Legal and Investigation Expense	600.00
Building Maintenance	4,879.52
Depreciation Library—10%	81.80
Perodical Publications	24,740.62
	$ 51,908.87

The audit embraced an exhaustive test of the various sources of income and the verification of the cash disbursements with proper vouchers on file.

We are pleased to report that we found the accounting records to have been kept in the usual good order and that every facility was afforded us for the proper conduct of the audit.

Yours truly,

MARWICK, MITCHELL & Co.

Report of the Judicial Council

To the Members of the House of Delegates of the American Medical Association:

At the New Orleans session of the House of Delegates, a resolution was adopted requesting the Judicial Council, at the next annual session, to report "a concrete proposition" or plan for reducing the number of Trustees of this Association from nine to seven and to subdivide the United States into seven Trustee Districts.

Under the present plan there are nine trustees, each elected for three years, the term of service being so arranged that the terms of three trustees expire each year. There are, therefore, three trustees to be elected each year for a term of three years. If the House of Delegates shall determine to reduce the number of trustees to seven, and if it is desired that the term of office of all of them shall not expire at the same time, the only satisfactory plan would be to make the term of office seven years instead of three years and to arrange so that the term of office of one trustee in rotation shall expire each year.

If then the House of Delegates should decide to make the change, the following plan is suggested: At the annual session in 1922 when the term of office of three trustees expires, elect one trustee for a term of seven years. In 1923 when the term of office of three more trustees expires, elect one trustee for seven years, one for five years and one for four years. In 1924, there will be four holdover trustees for terms of six, five, four and three years respectively, with three to be elected, one for a term of seven years, one for two years and one for one year. In 1925, there will be six holdover trustees for terms of six, five, four, three, two and one year respectively with one trustee to be elected for a term of seven years. Thereafter, there will be one trustee to be elected each year for a term of seven years.

Of course, before any change can be made in the number of trustees, it will be necessary for the trustees to change the Articles of Incorporation, as the number of trustees is fixed in the present Articles of Incorporation. The House of Delegates can direct the Board of Trustees to have the necessary changes made in the Articles of Incorporation any time during the coming year, but the change in the Constitution would have to be proposed this year and lie over one year before it could be adopted and become operative.

For the subdivision of the United States into seven trustee districts, the following is submitted as a tentative proposition:

	Number of Members	Number of Delegates
FIRST DISTRICT		
Maine	657	1
New Hampshire	506	1
Vermont	380	1
Massachusetts	3,975	5
Rhode Island	376	1
Connecticut	1,007	2
New York	8,819	11
Total	15,720	22
SECOND DISTRICT		
Pennsylvania	7,362	9
New Jersey	1,816	3
Delaware	129	1
Maryland	1,262	2
District of Columbia	545	1
Virginia	1,828	3
West Virginia	1,091	2
Total	14,033	21
THIRD DISTRICT		
Ohio	4,552	6
Indiana	2,423	3
Illinois	6,978	8
Michigan	2,815	4
Total	16,768	21
FOURTH DISTRICT		
North Carolina	1,598	2
South Carolina	631	1
Georgia	1,225	2
Florida	577	1
Alabama	1,664	3
Mississippi	481	1
Tennessee	1,701	2
Kentucky	2,039	3
Total	9,916	15
FIFTH DISTRICT		
Louisiana	1,081	2
Arkansas	1,195	2
Missouri	3,329	5
Oklahoma	1,293	2
Texas	3,547	5
Total	10,445	16
SIXTH DISTRICT		
Iowa	2,276	3
Wisconsin	1,938	3
Minnesota	1,507	2
North Dakota	454	1
South Dakota	396	1
Nebraska	1,182	2
Kansas	1,581	3
Total	9,334	15

SEVENTH DISTRICT

Montana	374	1
Wyoming	97	1
Colorado	852	2
New Mexico	272	1
Arizona	245	1
Utah	233	1
Idaho	223	1
Washington	985	2
Oregon	606	1
Nevada	88	1
California	3,328	3
Canal Zone	74	1
Hawaii	81	1
Philippine Islands	158	1
Porto Rico	155	1
Total	7,771	19

The foregoing division makes provision so that no one state will have the majority of the delegates in the district in which the state is included.

As already stated, the foregoing is presented to the House, not as a recommendation from the Judicial Council, but in response to the action taken by the House of Delegates requesting the Judicial Council to submit a plan which will effect the change provided the House deem it advisable to do so.

During the past year one case has been presented to the Judicial Council for adjudication. This is an appeal of the Spokane County Medical Society from an action of the Washington State Medical Association. The question raised did not seem to warrant the calling of a special meeting of the Council, especially in view of the short time intervening before the next regular meeting of the Council at the annual session. The case, therefore, will be taken up at the regular meeting of the Council at this annual session, when a full report on this question will be made to the House.

Respectfully submitted,

M. L. HARRIS, Chairman,
I. C. CHASE,
H. A. BLACK,
RANDOLPH WINSLOW,
WILLIAM S. THAYER,
A. R. CRAIG, Secretary.

Report of the Council on Health and Public Instruction

To the Members of the House of Delegates of the American Medical Association:

The Council has continued during the past year to develop the program which it adopted in 1914 and which it has followed since that time. This program includes three main objects, namely:

I. Investigation of the existing health conditions with a view to securing accurate information on all phases of the public health situation.

II. Education of the public and the profession by every means within the resources of the Council, in order that the public may understand the advance of scientific medical knowledge and the possibility of utilizing such knowledge in the prevention of disease, the reduction of the death rate and the preservation of human lives.

III. The crystallization of public sentiment into such practical health laws, regulations and ordinances as may be necessary for the conservation of human life.

Reorganization of Federal Public Health Activities

In the report of the Council for 1920, the situation existing at that time regarding public health reorganization was stated at length as well as the cooperative efforts which had been undertaken by the Joint Committee of the Council, the State Health Officers Association and the American Public Health Association. In accordance with the action of the House of Delegates, the Surgeon-General of the United States Public Health Service was requested to designate three officers of the Public Health Service to cooperate with this committee. In accordance with this request Surg.-Gen. Hugh S. Cumming designated Assistant Surgeons-General Allen W. McLaughlin, W. S. Warren and J. W. Schereschewsky to cooperate with the Joint Committee.

Following the reassembling of Congress on December 4, 1920, efforts were made to secure the passage of House Resolution No. 33. Almost immediately after Congress reassembled, however, a joint resolution was introduced in the Senate by Senator Smoot of Utah, and in the House, by Mr. Reavis of Nebraska, providing for a congressional committee to make a survey and prepare a report on the reorganization of the executive departments of the federal government. This resolution passed both Houses and became a law without the President's signature. As the scope of this resolution was

much broader than that of Resolution No. 33, it was impossible to secure the consent of the Republican Steering Committee to consider the later measure. Following the passage of the Smoot-Reavis resolution the following Joint Congressional Committee was appointed: Senators Reed Smoot of Utah, James W. Wadsworth of New York, and Pat Harrison of Mississippi, and Representatives C. F. Reavis of Nebraska; H. T. Temple, Pennsylvania, and R. W. Moore, Virginia.

Efforts are now being made to secure information regarding the plans of this committee and as to whether they are taking up public health as one of the first subjects to be considered; whether it will consider this subject in committee of the whole or will appoint a subcommittee thereon, etc.

ATTITUDE OF THE ADMINISTRATION ON PUBLIC HEALTH

During the presidential campaign of 1920, Senator Harding repeatedly stated in his speeches that he regarded public health and human welfare as two of the most important subjects for governmental activity and that, if elected President, he would favor the creation of a Department of Health and Welfare with a secretary in the cabinet. Following his inauguration, he commissioned his personal physician, Dr. Charles E. Sawyer of Marion, Ohio, as brigadier-general in the Medical Reserve Corps and assigned to him the special duty of collecting evidence and preparing plans for the development of the health and welfare work of the federal government.

HEALTH MEASURES BEFORE CONGRESS

With the termination of the Sixty-Sixth Congress on March 4, 1920, all the measures before both Houses at that time were wiped off the calendar. Since the reassembling of Congress on April 11, the following bills have been introduced up to date of the compilation of this report:

HOUSE BILLS

H. R. 3.—Establishment of Veterans' Bureau, Transferring to It Powers and Duties of War Risk Insurance Bureau and Federal Board for Vocational Training.
H. R. 7.—Creation of an Educational Department, with Appropriation Including Federal State Aid.
H. R. 19.—Provision for Vocational Rehabilitation of Disabled Soldiers.
H. R. 21.—Provision for Vocational Education by Federal State Aid.
H. R. 22.—Creation of a Division of Physical Education.
H. R. 65.—Amending Food and Drug Act of 1906 and Amendments of 1912.
H. R. 116.—Granting Physicians Licensed to Practice in any State, Right to Practice in all States.
H. R. 2193.—Amendment to Third Harrison Law Regulating Importation and Use of Opium.

H. R. 2287.—Amending Vocational Rehabilitation Act of June, 1918, as Amended July, 1919.
H. R. 2492.—Increase of Appropriation for Naval Hospital at San Diego, Calif. to $1,975,000.
H. R. 2501.—Increase of Age Limit of Officers in Medical Reserve Corps to 45.
H. R. 2918.—Creation of Osteopathic Board in District of Columbia.
H. R. 2920.—Establishment of Columbia Training School for Feeble-minded Persons in District of Columbia.
H. R. 3186.—Provision for Pensioning Mothers Having Dependent Children under 16.
H. R. 3187.—Provision for Pensioning Aged Poor, Needy Blind and Others Permanently Disabled Whose Income Is Less than $500.
H. R. 4104.—Provision for Purchase and Free Distribution of Antirabic Virus.
H. R. 4109.—Provision for Destruction of Animals Affected with Diseases Endangering Human Health.
H. R. 4118.—Control of Venereal Disease in District of Columbia.
H. R. 4130.—Appropriation of Funds to Increase Compensation for all Enlisted Soldiers and Other War Workers.

SENATE BILLS

S. 322.—Provision for Naturalization of Aliens and Children of Aliens.
S. 408.—Establishment of Department of Social Welfare, Taking Over Public Health Service, Children's Bureau and Bureau of Industrial Housing and Transportation.
S. 416.—Provision for Physical Education.
S. 526.—Establishment of Department of Health.
S. 758.—Prohibition of Animal Experimentation in District of Columbia and Territories.
S. 802.—Incorporation of American Society for Control of Cancer.
S. 810.—Amendment to Medical Practice Act in District of Columbia.
S. 1039.—Provision for Protection of Maternity and Infancy by Means of Federal State Aid.
S. 2287.—Establishment of Vocational Rehabilitation for Disabled Soldiers.

COORDINATION OF VOLUNTARY PUBLIC HEALTH ACTIVITIES

Definite progress in this field has been made during the past year. Members of the House of Delegates will recall that one of the fundamental objects of the Council for eight years past has been the federation and amalgamation of the existing voluntary public health organizations with a view to securing better coordination in this field.

During the summer of 1920, a survey of existing organization was made by Dr. Donald B. Armstrong of the National Tuberculosis Association under the direction of the American Red Cross and the National Tuberculosis Association. Data regarding existing organizations were collected as well as the personal opinions of over one hundred individuals. Plans for coordination were discussed at conferences and by correspondence with the result that an informal conference was called at Washington on October 18, 1920, at the Red Cross headquarters, followed by a formal conference on December 10, attended by representatives of the American Red Cross; the National Tuberculosis Association; the Amer-

ican Social Hygiene Association; the American Public Health Association; the Council on Health and Public Instruction of the American Medical Association; the Mental Hygiene Association; the National Child Health Council; the National Association for Public Health Nursing; the State Health Officers Association, and the Rockefeller Foundation. At the December conference, the National Health Council was organized, a Constitution and By-Laws were adopted and the following officers elected: Chairman, Dr. F. Livingston Farrand, American Red Cross; vice chairman, Lee K. Frankel, New York; secretary, Dr. C. St. Clair Drake, State Health Officers Association. An appropriation of $30,000 for two years has been made by the American Red Cross. Permanent headquarters have been established in Washington and a temporary business office at New York. The Service Committee of the National Health Council has leased two floors of the Penn Terminal Building, directly opposite the Pennsylvania Railroad Station and has sub-let office space to the organizations having headquarters in New York. The American Public Health Association has moved its headquarters from Boston to New York, so that all of the organizations composing the National Health Council with the exception of the American Medical Association, the American Red Cross and the State Health Officers Association have headquarters under the same roof, with mutual arrangements for cooperation and service among themselves.

The National Health Council is proceeding slowly and is developing a marked spirit of cooperation, which, it is hoped, will result eventually in working out a common plan of procedure. Applications for admission from a large number of organizations are now being considered and plans are being developed for securing financial support for a constructive program.

VITAL STATISTICS LEGISLATION

In this field, also, the Council on Health and Public Instruction is glad to report definite progress during the past year. In its report for 1920 the Council showed that in 1906, when this work was first undertaken, only ten states in the Union had effective laws for the registration of deaths and only eight states had any laws requiring the registration of births; that during the fourteen years from 1906 to 1920 the Model Bill, developed by the

Council in cooperation with the Division of Vital Statistics of the United States Census Bureau and other contributing organizations had been adopted by forty-three states. During the past winter this bill was introduced in the state legislatures of South Dakota, Iowa and West Virginia and was adopted practically without opposition in Iowa and West Virginia, making forty-five states which now have adopted this measure; the largest number of states that have adopted any standard bill on any subject. The only three states that have not yet adopted it are Arizona, Nevada and South Dakota. The Arizona legislature meets in November and it is hoped that this bill can be introduced and passed at that time. The failure of this bill to pass in South Dakota was due largely to lack of education of the public and to a misunderstanding of its provisions. It is almost certain that this measure will be adopted at the next session of the legislature. Regarding Nevada, the large size and the scant population of this state may make it necessary to modify the standard bill somewhat, but as its population amounts to only 77,000 the absence of this state from the registration area will not impair the value of our national vitality statistics. With only three states still to adopt this measure, the end of this work to which the Council and Association has very materially contributed in the last eighteen years is now clearly in sight.

ANTI-VIVISECTION LEGISLATION

During the past winter, out of the forty-two states whose legislatures were in session bills for the prevention of animal experimentation were introduced in four states, viz., Massachusetts, New York, Indiana and Maine. In Maine the bill was dropped. In Massachusetts hearings on the bill were set, but as no one appeared in favor of it, the committee voted not to report it out. In Indiana and New York the bill was killed in committee.

For the first time in the history of efforts to abolish annual experimentation an appeal was made last November in California to popular vote through use of the initiative. The proposed legislation provided for strict abolition of all use of animals "for the purpose of experimental physiological or experimental pathological investigation in or at any university, school, society, college, hospital and institution, or other places within the state of California." The campaign was conducted intensively by both the proponents and the oppo-

nents of the measure. At the final vote, it was defeated by a majority of approximately 250,000 votes.

ORGANIZATION OF THE EYE SIGHT CONSERVATION COUNCIL

In the report for 1920, attention was called to the discussion then going on among representatives of the American Optical Association, large optical manufacturing companies, representatives from scientific organizations, etc., with a view to the inauguration of a campaign for the education of the public on the conservation of vision and the detection and correction of errors of vision, especially among school children, industrial employees, etc. The secretary and Dr. Cassius D. Wescott, chairman of the Council Committee on the Conservation of Vision, were invited to attend several of these conferences. In the fall of 1920, the Eye Sight Conservation Council was organized. Its membership is made up of various organizations devoted to human welfare and betterment, with a business committee to finance it, made up of the representatives from large manufacturers. Dr. Wescott was elected vice president and the secretary was asked to serve on the Board of Councillors. These appointments were accepted with the proviso that all literature and publicity material for public use should be passed on by the two representatives of the Council—a condition to which the Eye Sight Conservation Council agreed. Plans for the work of the Council are now being formulated.

COOPERATION WITH THE NATIONAL EDUCATION ASSOCIATION

The Committee on Cooperation with the National Education Association has sent in a separate report which appears herewith. (See Appendix *A*.)

The Council wishes to call attention to the fact that in response to its request that the state societies appoint state committees on this subject to cooperate with the states' teachers' associations, special committees having been appointed in thirty-four states, as follows: Alabama, Arizona, Arkansas, Colorado, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Utah, Vermont and Wisconsin.

Arrangements for a meeting of the state committees during the time of the Boston Session of the American Medical

Association have been made for conference purposes and for the development of uniform plans. A recent development in this field is the appointment by the American Public Health Association of a Committee on Health Teaching in the Public Schools, which may easily be expanded into a Committee on Health Problems in Education that will cooperate with the Joint Committee of the American Medical Association and the American Education Association.

MIDWINTER CONFERENCE

The Midwinter Conference was held March 7-10, 1921. On the fourth day of the conference a special program was presented by the Council, as follows:

MORNING PROGRAM—9:30 A. M.

Rural Health Centers

Rural Health Centers as an Aid to General Practitioners, Victor C. Vaughan, M.D., Chairman, Council on Health and Public Instruction, American Medical Association, Ann Arbor.

What We Have Done in Iowa, F. E. Sampson, M.D., Creston, Iowa.

General Discussion opened by Frank Billings, M.D., Chicago.

AFTERNOON SESSION—2 P. M.

The Organization of the Public for Health Work

From the Standpoint of the Council on Health and Public Instruction of the American Medical Association, W. S. Rankin, M.D., Secretary, North Carolina State Board of Health, Raleigh, N. C.

From the Standpoint of the State Health Officer, S. J. Crumbine, M.D., Secretary, Kansas State Board of Health, Topeka, Kan.

From the Standpoint of the State Medical Society, F. C. Warnshuis, M.D., Secretary, Michigan State Medical Society, Battle Creek, Mich.

From the Standpoint of the State Public Health Association, Celestine J. Sullivan, Secretary, League for the Promotion of Public Health, San Francisco.

From the Standpoint of the Voluntary Public Health Association, Charles J. Hatfield, M.D., Secretary, National Tuberculosis Association, New York.

From the Standpoint of the Business Man, Lee K. Frankel, Third Vice President, Metropolitan Life Insurance Company, New York.

From the Standpoint of Women's Organizations, Lena L. Meanes, Woman's Foundation for Health, New York.

PROPOSED AMENDMENTS TO THE HARRISON LAW

No attempt has been made during the past year to amend the Harrison law which regulates the registration of physicians and the prescribing or dispensing of habit-forming drugs. On December 6, 1920, a bill was introduced in the Senate by Senator Jones of Washington (S. 4533) and in the House by Mr. Miller of Washington (H. R. 14500) amending Section 6 of the second Harrison law so as absolutely to prohibit any exportation of opium or cocaine or their derivatives from the United States to any foreign country or the shipment "in transit" through this country of any of these drugs, and to restrict importation of opium into this country to such amounts as shall be found necessary for actual medicinal use by the Surgeon-General of the United States Public Health Service. Following a large number of hearings before both the House and the Senate committees, Mr. Rainey introduced on Jan. 4, 1921, a substitute for the Jones-Miller bill, which on January 18 was introduced in the Senate by Senator Curtis (H. R. 15511, S. 4895). The Curtis-Rainey bill permits exportation to those countries which have adopted the provisions of Article 13 of the Hague Convention of 1912, and limits importation to such amounts as the Secretary of the Treasury and the Secretary of Commerce may find to be necessary for medicinal purposes.

In accordance with the instruction of the House of Delegates at the New Orleans meeting, the Council appointed as a subcommittee on this subject Dr. Haven Emerson of New York; Dr. A. C. Prentice of New York; Dr. George W. McCoy, United States Public Health Service, Washington, D. C.; Dr. Thomas S. Blair, State Health Department, Harrisburg, Pa. The report of this special committee is appended herewith (Appendix B).

THE TREATMENT OF TUBERCULOUS PATIENTS IN GENERAL HOSPITALS

At the New Orleans Session a telegram from the Surgeon-General of the United States Public Health Service was presented urging the active participation by general practitioners and general hospitals in the treatment of tuberculosis. At the meeting of the Council, held November 11, 1920, a communication from the Surgeon-General on this subject was received and the Surgeon-General was requested to formulate the action which he wished the Council and the Association

to take. In response to this request the following resolution has been submitted which is herewith referred to the House of Delegates for action with the recommendation that it be adopted:

WHEREAS, There is an unfortunate tendency in various parts of the United States to exclude patients even of tender years, with pulmonary tuberculosis from general hospitals; and

WHEREAS, This tendency results chiefly from incomplete knowledge of an earlier period when the simple prophylactic measures were not thoroughly understood and when the dangers of dissemination were greatly overestimated; and

WHEREAS, The exclusion of tuberculous patients from general hospitals has resulted in depriving large numbers of tuberculous patients from proper hospital care in emergencies and their exile against their wishes, to special institutions often remote from home and friends; and

WHEREAS, This practice has resulted in the relegation of tuberculosis largely to specialists, to the great detriment both of tuberculous patients who are compelled to seek in special places the necessary medical skill, and of the general practitioner who is thus deprived of the opportunity to acquaint himself with the diagnosis and treatment of tuberculosis; and

WHEREAS, It has been demonstrated in a rapidly increasing number of institutions that tuberculous patients may be admitted into separate wards in general hospitals without detriment to other patients; and

WHEREAS, The admission of tuberculous patients to general hospitals for temporary periods will tend to allay phthisiphobia, improve the home treatment of tuberculosis and popularize the home climates without in any way discounting the value and need of special tuberculosis sanatoria for patients suitable for and desiring treatment therein; be it

Resolved, That the American Medical Association recommends that general hospitals in all parts of the United States should provide separate wards or separate rooms for the care of tuberculosis patients, and that such patients be never denied admission, at least in emergency and for temporary periods, because of the character of the disease from which they are suffering.

VENEREAL DISEASE CONTROL

At the meeting of the Council, held March 9, 1921, a communication was received from Surg.-Gen. Hugh S. Cumming regarding the teaching of medical students in the diagnosis and treatment of venereal diseases. At the request of the Council the Surgeon-General submitted the following resolution:

Resolved, That the venereal disease control movement cannot reach full effectiveness without the intelligent and sympathetic cooperation of the medical profession, and that this cooperation should include the rapid extension of teaching facilities for the use of medical students whereby the knowledge of the medical, social and public health aspects of these diseases may be taught by actual clinical contact with patients in the clinic, under the direction of qualified teachers.

While the Council realizes that this question, in so far as its educational problems are concerned, belongs to the Council on Medical Education and Hospitals, it also feels that there are sufficient public health features in the question to

justify the presentation of this resolution to the House of Delegates with the recommendation that it be adopted.

NATURE AND HISTORY OF SYPHILIS

At the New Orleans Session the House of Delegates referred to the Council a resolution from the Section on Dermatology and Syphilology regarding the need of more complete clinical records. At the meeting of the Council on July 9, 1920, Dr. Sanger Brown, who originated the resolution, was present, on invitation. After discussion of the question, the Council authorized Dr. Brown to consult the Interdepartmental Social Hygiene Board, the Rockefeller Foundation, the United States Public Health Service and the American Social Hygiene Association regarding his plans with the approval of the Council.

NATIONAL CONFERENCE ON LEPROSY

At the New Orleans Session a resolution from the Section on Preventive Medicine and Public Health requesting the calling of a National Conference on Leprosy was referred to the Council. At the meeting of the Council on July 9, 1921, a communication from the Surgeon-General of the United States Public Health Service was presented, recommending the deferring of this conference until later, in order to give opportunity for the observation of the operation of the National Leprosarium, recently established.

MIGRATION OF INDIGENT CONSUMPTIVES

At the New Orleans Session a resolution on this subject was presented and referred to the Council. Dr. Haven Emerson was appointed as a special committee on this subject. A preliminary report was presented at the time of the Council meeting on Nov. 7, 1920, but in view of the fact that the results of a study still in progress undertaken by the National Tuberculosis Association are not yet available, the presentation of a formal report on this subject is deferred until a later period.

REFERENDUM ON HEALTH QUESTIONS IN CALIFORNIA

During the summer of 1920, there was presented for the consideration of the voters of California four propositions under the Initiative and Referendum law in the form of

amendments to the state constitution. They appeared on the ballot as Proposed Amendments 5, 6, 7 and 8. Number 5 created a chiropractic board of examiners; No. 6 prevented any form of animal experimentation; No. 7 forbade compulsory vaccination or the exclusion from the public schools of unvaccinated children; No. 8 gave osteopaths the right to prescribe drugs. The Council at its meeting on July 11, 1920, voted to cooperate with the Medical Society of California and the California League for the Conservation of Public Health to the extent of its ability. At the November election all four of the propositions were defeated by majorities ranging from 200,000 to 350,000.

SOCIAL RELATIONS OF THE MEDICAL PROFESSION

At the New Orleans meeting of the Association, the House of Delegates adopted the following resolution:

Resolved, That the Council on Health and Public Instruction be instructed to investigate the relative adequacy of the medical service and the relation of the public to the profession and to report at the next annual session.

At the meeting of the Council, held July 7, 1920, there were present, in addition to the Council, on invitation, the following: Dr. Frank Billings, secretary of the board of trustees; Dr. George H. Simmons, general manager and editor of THE JOURNAL; Dr. George E. Vincent, president of the Rockefeller Foundation; Dr. J. W. Schereschewsky, representing the Surgeon-General of the United States Public Health Service; Dr. C. St. Clair Drake, director of public health of the state of Illinois and secretary of the State Health Officers' Association. The chairman of the Council presented the following statement:

PROPOSITIONS TO BE LAID BEFORE THE COUNCIL ON PUBLIC HEALTH AND LEGISLATION OF THE AMERICAN MEDICAL ASSOCIATION TO BE HELD IN CHICAGO, JULY 9, 1920

I assume that the chief aim of the medical profession is to reduce the morbidity and mortality to a minimum.

On this assumption the medical profession should ask itself to what extent it is now accomplishing this aim and what should be done to improve its work in this direction. I am therefore submitting to the Council for debate the following propositions:

1. Have we enough doctors in this country?
2. Are they doing the work as it should be done?
3. What steps should be taken to induce our medical schools to better prepare our doctors?
4. It is generally admitted that the best medical schools do not give adequate instruction in preventive medicine. What shall be done to improve education in this line?

5. It is generally admitted that the average physician deteriorates after leaving the medical school. What can be done to prevent this?

6. Is the American Medical Association manifesting sufficient interest either in preventive medicine or improving the conditions under which the average doctor practices his art?

7. What steps can the American Medical Association take to secure better qualified physicians and to stimulate those now in practice to better work?

8. Should the American Medical Association devote more time, energy and money to preventive medicine?

9. Should the Council advise the House of Delegates at its next meeting to request the Board of Trustees to publish a public health journal with some such title as the following: *Journal of Preventive and Curative Medicine?*

10. What should the attitude of the American Medical Association be toward community medicine and the establishment of community hospitals?

11. What should be the attitude of the American Medical Association toward the various voluntary health organizations now operating in the country, such as the International Health Board, the American Red Cross, the National Tuberculosis Association, Child Welfare Society, etc.?

12. Should not the Council on Public Health and Legislation attempt to present to the House of Delegates at its next meeting a definite program showing the attitude of the Association toward all preventive agencies and to the improvement of conditions under which the practice of medicine is pow proceeding in this country?

Following a lengthy discussion a committee was appointed consisting of five members of the Council, with the following additional members: Dr. Frank Billings, Chicago; Dr. Herman Biggs, New York; Dr. Hugh Cabot, Ann Arbor, Mich.; Dr. F. E. Sampson, Creston, Iowa. This committee held a meeting on November 11, 1920. At this meeting there were present, besides the members of the committee: Dr. Hubert Work, president-elect of the American Medical Association; Dr. Wendell Phillips of the board of trustees and others. After a lengthy discussion the following statement was formulated and published in THE JOURNAL for December 4, 1920:

1. The Council believes it highly desirable that the nature and transmission of communicable diseases should be taught in the public schools of the country. This is already a legal requirement in a few states. In other states such instruction is confined to tuberculosis. The secretary of the Council was requested to gather such information as he may be able to find bearing in this matter and to have framed a model bill for introduction into the legislatures of the states which do not already provide for such instruction.

2. The Council believes that teachers in our public schools should know something about the communicable diseases and what should be done with pupils under their charge developing these diseases. The Council believes that a course in epidemiology should be required in all normal schools and in schools of education in our universities; in short, that no one should be licensed to teach without having had instruction in epidemiology. The secretary of the Council was requested to have formulated a model bill bearing upon this subject.

3. The Council is of the opinion that there should be a closer coopera-

tion between the medical profession and laymen who are interested in public health, and the Council recommends that sections on public health and sanitation be organized in state and local medical societies, and that laymen interested in public health be admitted as associate members of this society and referred to the sections. In the opinion of the Council, this matter should be discussed more fully at the next meeting of the Council in March, 1921.

4. In the opinion of the Council, it is highly desirable that the American Medical Association should, as soon as possible, begin the publication of a popular, up-to-date journal on sanitation and epidemiology, which should give to the public the latest, most complete and most scientific information concerning the prevalent and communicable diseases. It is the wish of the Council that this matter be referred to the Board of Trustees of the American Medical Association.

5. The Council on Health and Public Instruction believes that the American Medical Association should take steps to secure the following results:

(*a*) To assist local medical practitioners by supplying them with proper diagnostic facilities.

(*b*) To provide for residents of rural districts, and for all others who cannot otherwise secure such benefits, adequate and scientific medical treatment, hospital and dispensary facilities and nursing care.

(*c*) To provide more efficiently for the maintenance of health in rural and isolated districts.

(*d*) To provide for young physicians who desire to go to rural localities, opportunities for laboratory aid in diagnosis.

(*e*) The Council believes that these results can be best secured by providing in each rural community a hospital with roentgen-ray and laboratory facilities to be used by the legally qualified physicians of the community. The secretary of the Council was requested to study the laws of the different states bearing upon this subject and to prepare a model bill to be studied more fully at the meeting of the Council in March, 1921.

At the Midwinter Conference the morning program was devoted to a discussion of health centers and rural hospitals and the afternoon to the organization of the public for health work.

At the meeting of the Council, held March 9, 1921, the secretary presented a report on state enabling acts for the erection of county hospitals, showing the present condition of state legislation on these subjects. This report is submitted in Appendix C.

The Council also voted to use the Iowa law as a basis for discussion and criticism. The text of the Iowa law is submitted in Appendix D.

The Iowa law with the abstract of the state legislation on the subject of rural hospitals has been printed in pamphlet form and distributed widely for criticism and suggestion throughout the country. During the winter of 1921-1922 state legislatures will meet in only a few states, so that we have

a year and a half in which to prepare a model bill on a constructive public health plan which will carry out the plans of the Council as expressed in its formal statement.

TEACHING OF HEALTH IN THE PUBLIC SCHOOLS

In accordance with the instruction of the Council the secretary sent a letter to the secretary of the state board of health in each state, asking whether there was any law requiring the teaching of communicable diseases in the public schools or requiring the instruction of teachers on the subject of communicable diseases and their prevention. Replies from twenty-eight states showed that laws had been adopted in five states—Idaho, Kentucky, Utah, Michigan and Virginia. All five of the laws are largely modeled on the Michigan Act of 1895, which is submitted in Appendix E. The Council has taken this law as the basis for a model law and has had copies of it printed and distributed for criticism and suggestion.

ATTITUDE OF THE ASSOCIATION TOWARD SECTARIANISM

During the past year the efforts of the so-called "chiropractors" to secure the passage of bills creating independent boards for examining and licensing followers of this cult, have created considerable disturbance in the ranks of the medical profession, especially in some of our western states. Apparently, this cult is about to repeat the experience of homeopathy, osteopathy and other sects. The natural history of each of these cults is the same. Originating as a fantastic method of treatment, generally conceived by some individual without scientific training but with marked evangelistic ability, it has been taken up as the central idea of a cult and preached with a zeal and fanaticism equalled only by religious devotees. Supported by that portion of the public that is attracted by anything new and fantastic; growing on opposition and discouragement, and developing a fervor, devotion and influence far out of proportion to their numbers, each sect has risen, gathered adherents and flourished for a little while, and eventually dropped its peculiarities, discarded its distinctive and absurd doctrines and finally either disappeared or has been absorbed into the ranks of the general medical profession. This has been the history of the sects of the past. Such a process is now going on in osteopathy. Each generation of physicians regards the sects and cults of their day as entirely unique, forgetting that many sects in medicine

have existed and disappeared in the past and that many more will probably appear in the future. Each generation attempts to suppress the sects of its day by much the same methods, and with about the same degree of success. In spite of all our efforts and often aided by our mistakes, each sect goes through the same cycle and its duration is usually limited to a generation or two. Stimulated partly by personal motives and partly by a desire to protect the public, physicians have at all time sought to suppress these sects. But the methods used have often been short-sighted and ill-advised, and as a result, the attitude of the medical profession on sectarianism has been in the past, and is at present, confused and impractical, often defeating the purposes in view, viz., the protection of the public from fraud and charlatanism and the maintenance of professional standards. Physicians have always insisted on discussing sectarianism from the standpoint of its scientific claims, forgetting that both the public and the legislators are unfitted to appreciate or decide scientific questions. The question is not a scientific one, neither is it one which can ever be settled even temporarily by the use of partisan or repressive measures. It is essentially a question of popular psychology, and the remedy lies in education and not in legislation. Until the public is taught to distinguish between true scientific progress and pseudo-scientific propaganda, cults and sects in medicine will have a certain amount of popular support. Our efforts to control the situation in the past has been largely ineffective, because we have not attempted to enlighten public ignorance, which is the essential factor, but have attacked the cults themselves, which are the result and not the cause. Our efforts have not only been futile but they have been irritating and have consumed time and energy which could much better be devoted to other purposes. The attitude of physicians towards sects in the past has been neither dignified nor effective. This is the situation which organized medicine must meet, and which, so far, it has not met intelligently. The Council, therefore, recommends that it be instructed to appoint a committee to study the entire question of sects in medicine and the attitude which the American Medical Association should adopt regarding them and to report at a future session.

THE VALUE OF VACCINATION

Another subject of much controversy at present is that of compulsory vaccination. For many years the value of vaccination as a means of preventing smallpox has been so univer-

sally recognized by all intelligent physicians and competent health officials, that little attention has been given to the collection and tabulation of statistics on smallpox and vaccination. In a number of states, especially those western states which have adopted the initiative and referendum, there has developed an organized effort to repeal all laws providing for compulsory vaccination. The literature used in this campaign contains the most exaggerated and misleading claims regarding the character of smallpox, the reasons, other than vaccination, for its reduction, the nature and dangers of vaccination, etc. The statements made are often so general, so sweeping and so misleading as to require a discussion of the entire subject to answer them specifically. It is impossible for the individual physician to devote the time and labor required for such a task. Educational material covering the entire subject, tabulating all the available statistics, and especially specifically replying to and refuting the statements made in the antivaccination literature, is needed to meet the situation. This is a work which must be done, partly by health officers, partly by the statistician and partly by educators. To accomplish this purpose, the Council requests that it be authorized to appoint a committee to survey the entire subject and to prepare suitable material for educating the public on this question.

ORGANIZATION OF THE PUBLIC FOR HEALTH WORK

But both of these subjects are part of a greater question, namely, the effective education of the public in securing better conditions for its own protection. The people can only protect themselves as they become better informed regarding the advance in our knowledge of the cause of disease and its prevention. This requires public education on a large scale. Even if physicians were fitted for such work and could afford to take the time necessary for it, the cost of such education, if properly carried on, is far beyond the resources of the medical profession. Neither is there any reason why we should be expected to pay for the education of the public. Yet the public must be properly taught and properly guided, and whatever form such guidance may take, a certain amount of organization of the public is necessary in order to carry out such instruction effectively. In the numerous organizations now in this field, we may see the results of efforts along this line which have been made without any definite plan or effort at coordination. Out of the existing chaos which has been developing for the last twenty-five years, there must

come some kind of order and coordination. The public must be organized in some effective fashion for the conservation of health. What is going to be the character of such organization? Does the solution lie in the admitting of selected laymen to membership in our medical organizations, as suggested by the chairman, in the continued organization and multiplication of individual voluntary organizations in the health field such as now exist; in the gradual conversion of the most vital of these special organizations into public health organizations with an unlimited field; in the concentration of all public efforts into some one existing organization, as was suggested in the case of the American Red Cross; in the organization of state public health leagues de novo; in professional bodies such as the League for the Conservation of Public Health which achieved such a signal victory in California last November; or in some new and as yet unformulated plan of organization?

These are questions which at present no one can answer. The discussion which developed on this subject at the Midwinter Conference and the interest manifested seems to warrant further consideration. The Council, therefore, requests the House of Delegates to authorize it to call a conference in Chicago during the coming summer, probably in July, to which shall be invited the general officers of the American Medical Association; the presidents and secretaries of the constituent state associations; the presidents and secretaries of county and local medical organizations; the presidents and secretaries of the various voluntary state and national public health organizations, and the health officers of the various states for the discussion of the present situation with a view to formulating a plan for the organization of the public for health work.

EDUCATIONAL MATERIAL ISSUED FROM MARCH 17, 1920, TO MAY 1, 1921

The following pamphlets, cards, charts, etc., have been printed:

Baby Welfare		
Score Cards	20,000	
Record Sheets	26,000	
Antropometric Tables	500	
Posters	1,600	
		48,100
Rules Regarding Animals	200	
		200
Vision Charts	500	
		500
Total cards		48,800

PROTECTION OF RESEARCH		
I	1,000	
IX	1,000	
XXVII	1,000	
		3,000
CONSERVATION OF VISION		
II	1,000	
IX	1,000	
XI	1,000	
XX	1,000	
		4,000
HEALTH AND EDUCATION		
Minimum Health Requirements	1,000	
Health Charts	500	
Health Essentials	2,500	
		4,000
SEX EDUCATION		
Boys' Venereal Peril	5,000	
		5,000
BABY WELFARE		
Save the Babies	140,500	
Summer Care of the Baby	2,000	
How to Hold a Baby Welfare Conference	1,000	
		143,500
PUBLIC HEALTH		
Smallpox	2,000	
The House-fly	1,000	
Typhoid	4,000	
Pure Water	1,000	
Measles	4,000	
Scarlet Fever	3,000	
What You Should Know About Tuberculosis	370,000	
Child Welfare	1,500	
Cancer		
I	1,000	
VI	1,000	
X	12,000	
		400,500
MISCELLANEOUS		
Why Should Births and Deaths Be Registered?	4,000	
Health Insurance	2,000	
Narcotic Drug Situation	5,000	
Rural Health Centers as Aid to General Practitioners	5,000	
Enabling Acts and Digest of Michigan Law	5,000	
		21,000
Total pamphlets		581,000

Respectfully submitted,

VICTOR C. VAUGHAN, Chairman,
W. S. RANKIN,
HAVEN EMERSON,
MILTON BOARD,
W. B. CANNON,
FREDERICK R. GREEN, Secretary.

REPORTS OF SUBCOMMITTEES OF THE COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

APPENDIX A

COMMITTEE ON HEALTH PROBLEMS IN THE PUBLIC SCHOOLS

To the Council on Health and Public Instruction:

Your Committee on Health Problems in the Public Schools submits the following report of its activities for the year ending January 31, 1921:

1. At the summer meeting of the National Education Association, held in Salt Lake City in July last, one one-half day session was given for a public meeting on "Health in Our Schools" which was addressed by Dr. Wood, chairman of the Joint Committee, and others.

2. The tenth annual meeting of the Joint Committee of the National Education Association and the American Medical Association was held on Tuesday, March 1, at Atlantic City —the Hotel Traymore. Copy of the minutes of this meeting accompanies this report, and also a copy of the annual report of the chairman, Dr. Wood, which was by action of the committee approved.

We would call attention to item No. 10 of the report of the meeting at Atlantic City. We are confident that the officials of the National Council of Education and the National Education Association will use every possible effort to secure the cooperation of the several state teachers' associations with the state medical societies to extend and localize this movement for the betterment of health conditions in the schools of the several states.

Attention is also called to the report of the special committees (*a*) on school lighting and conservation of vision, of which committees Dr. Edward Jackson was chairman, and prepared a report, and (*b*) on ventilation and heating, of which committee Dr. R. W. Corwin was chairman. Copies of these reports are transmitted herewith.

In the afternoon of March 1, a public meeting was held in the First Presbyterian Church with an audience of about 200, Dr. Wood presiding. Brief addresses were made by Dr.

Wood and Dr. Dodson of your committee, Dr. Bolt of the National Child Welfare Association, Miss Katharine D. Blake of New York, Dr. Frankwood D. Williams of the National Committee for Mental Hygiene, and Mr. Thomas Finegan, commissioner of public instruction of the state of Pennsylvania.

3. The movement inaugurated by action of the House of Delegates in April, last, to extend this activity to the several states has progressed very satisfactorily.

In May, last, a letter was sent to the secretary of each state medical society reporting this action of the House of Delegates and urging that each society appoint, at its next meeting, a committee on health in the public schools, this committee to attend the next meeting of the State Teachers' Association, and ask for a similar committee from that body to form, with the committee of physicians, a joint committee. It was suggested that on the committee of (preferably five) physicians there be included, if possible, an oculist, a pediatrician, one who has been engaged in health work and one who has been actively interested in the public schools as a member of the school board or in some other way.

Up to the date of this report, the following state societies have indicated their purpose to appoint such committees: *Alabama, Arizona, Arkansas,* California, *Colorado, Connecticut, Georgia, Idaho, Illinois, Kentucky,* Louisiana, *Maine, Maryland, Massachusetts, Michigan,* Minnesota, Missouri, Mississippi, *Montana, Nebraska, Nevada, New Hampshire, New Mexico,* North Carolina, *Ohio, Oklahoma, Pennsylvania,* South Dakota, Tennessee, *Texas,* Utah and *Wisconsin.*

The states underscored have reported the personnel of their committee to the secretary of your Council.

When the personnel of a state committee has been reported to the Council a letter of suggestion as to the mode of procedure has been sent to each member. Copy of this letter is transmitted to the Council with this report.

4. Arrangements have been made to hold a conference of the members of the state medical society committees in Boston on the afternoon of Tuesday, June 7, just preceding the opening meeting of the American Medical Association, which is set for the evening of that day. It is believed that such a conference will be of material aid in promoting the extension and more effective conduct of this school health movement in the several states.

If in every state of the Union such a committee of physicians be appointed, cooperating with a similar committee of

teachers, there will be constituted a body of 800 or 900 persons seeking the betterment of health conditions and health education in the public schools. Kept in touch with each other and assisted by the National Joint Committee in the matter of securing information and material for a campaign of education, and, where necessary, legislation, these state committees should accomplish important results in this campaign.

It is recommended that this subcommittee be continued.

It is recommended that such sum as may be appropriated by the National Education Association for this work be duplicated by your Council, as has been the custom since the organization of the committee.

JOHN M. DODSON, Chairman,
R. W. CORWIN,
GEORGE W. GOLER,
EDWARD JACKSON.

April 8, 1921.

MINUTES OF THE ANNUAL MEETING OF THE JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION AT BREAKFAST CONFERENCE, HOTEL TRAYMORE, ATLANTIC CITY

In attendance: President Seerley, National Council of Education; P. P. Claxon, R. W. Corwin, John M. Dodson, Ada Van Stone Harris, John F. Keating, William B. Owen, Mrs. Ira Couch Wood, Dr. Bolt (present by request in place of Dr. L. K. Shaw); Thomas D. Wood, chairman.

The following motions were passed by the Joint Committee:

1. That the committee bulletin, "Health Essentials for Rural Schoolchildren," be revised by the chairman and then submitted to the members of the Joint Committee for criticism and approval.

2. That when revised and approved the bulletin on "Health Essentials" be reprinted through arrangement made by the chairman and Dr. Claxton.

3. That the manuscript on "Health Improvement in Rural Schools" be left in the hands of the special subcommittee and the chairman for revision and approval.

4. That, when completed and approved, arrangements for printing the report, "Health Improvement in Rural Schools," be made by the chairman and Commissioner Claxton.

5. The chairman is authorized to represent the Joint Committee in matters affecting reasonable forms of cooperation with the National Child Health Council.

6. That the chairman communicate with Dr. Edward Jackson, to express the appreciation of the Joint Committee to Dr. Jackson and his subcommittee for the very valuable report on "School Lighting" and arrange with Dr. Jackson for the publication of this report in full in such periodicals as THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, the *School Board Journal, School Life,* the *New England Journal of Education* and an architectural journal.

of the National Education Association
tendence, the following resolution and
Committee, viz.:

In view of the great importance of he
significant recognition of, and focusing
the Joint Health Committee strongly re
years one general session of each Nat
each meeting of the National Departmer
to the presentation of topics relating to

10. That the Joint Committee hearti
cooperation, in the various states, of s
cal organizations for the promotion of t
schools.

11. That Dr. Bolt be thanked for
of Dr. Shaw) at the meeting of our
information given by Dr. Bolt regardi
interested in child health.

APPENDIX

Report of Committee on Narcot
on Health and Publ

The Committee on Narcotic D
ton, and in New York City, and
correspondence and in person o
members and with others.

The Committee made its first
directions given at the time of its
on Health and Public Instruction,

Whereas, The Harrison Narcotic La
opiate drugs may be dispensed by a phy
fessional practice only," and may be dis
scription" of a physician; and

Whereas, The Supreme Court has

WHEREAS, It is desirable and important that the meaning of the law be made so clear that any physician dispensing or prescribing such drugs in any given case can know whether or not he is violating the law; and

WHEREAS, A clear and concrete knowledge of the acts which constitute a violation of the law will not only enable physicians to avoid its violation, but will also materially aid in the enforcement of the law against those who abuse their professional privileges; be it

Resolved, That a special committee be appointed for the purpose of calling upon the Attorney General of the United States and conferring with him as to the practicability of obtaining decisions from the United States Supreme Court which will remove existing uncertainties as to the meaning and application of the provisions of the Harrison Law above referred to; and further

Resolved, That Doctors Emerson, McCoy, Prentice and Blair be and they hereby are designated as such committee, and are hereby authorized and instructed to take the necessary steps to carry out the purpose of this resolution.

At a conference with a representative of the Attorney-General, in his office at Washington, the committee presented the problems stated in the above resolution. As the result of this conference, it was agreed by the Attorney-General's Office that a case would be prepared, by which it is hoped that a definition of medical practice will be reached, which will make clear the purpose and intent of the Harrison Law not to interfere in any way with the proper use of narcotic drugs in the legitimate practice of medicine, but equally not to permit the supplying of narcotic drugs to addicts, even under the guise of medical treatment to cure addiction.

Your committee also called on Mr. L. G. Nutt, director of the Narcotic Field Force of the Bureau of Internal Revenue of the Treasury Department, and transmitted to him the opinion of the Council on Health and Public Instruction, to the effect that the medical profession emphatically condemns the practice of distribution of the habit-forming narcotic drugs to addicts, in the course of their treatment for addiction, in such manner that the addicts may administer the drug themselves. Briefly, the so-called ambulatory treatment of addicts was condemned, whether practiced by the private physician, or in a public institution such as the so-called "narcotic clinic," and the director was urged to make use of the full powers of the Internal Revenue Bureau, under the law, to put an end to this practice.

It was learned that a survey was being made by the Internal Revenue Bureau, for the purpose of determining the amount of narcotic drugs actually imported, manufactured and distributed in the United States. This is regarded as a necessary first step to any accurate estimation of the probable need of habit-forming narcotic drugs in the practice of medicine in the United States.

A study was made of the work of Dr. Thomas S. Blair, chief, Bureau of Drug Control of the Department of Health of Pennsylvania, relating to the amount of habit-forming narcotic drugs, estimated on a per capita basis of opium or its equivalent, annually used in that state by physicians in private practice and in hospital practice.

On inquiry of the Council on Pharmacy and Chemistry of the American Medical Association, the following opinion regarding the therapeutic uses of habit-forming narcotic drugs was obtained:

"The principles governing the use of habit-forming drugs of this type may be stated as follows:

1. They should never be used unless they are deemed essential. In other words, they should not be used for minor affections.
2. No single habit-forming drug should be used continuously in the form of a preparation which the patient may use without the advice of a physician.
3. Morphin and heroin should not be used for symptoms which may be relieved by codein or other less actively habit-forming drugs.
4. The physician should take steps to insure a rigid control of the administration of any habit-forming drugs which he considers it essential to employ, in any particular instance.
5. Especial caution should be observed regarding the use of habit-forming narcotics in chronic conditions, other than those which are incurable, and in which morphin and other opium derivatives are indispensable."

In view of the information at hand, it was deemed wise to defer to a later date attempts to arrive at any quantitative estimation of the needs of habit-forming narcotic drugs in the United States.

Approaching the problem of the narcotic drug situation in its broad aspect, your committee respectfully presents for consideration, the following statement of facts and expressions of its opinions:

1. The International Treaty, known as one of The Hague Conventions entitled, "Suppression of the Abuse of Opium and Other Drugs," was concluded between the United States and other leading world powers in 1912, and was ratified by the Senate and proclaimed by the President of the United States in 1915. Such a fundamental undertaking appears to have been necessary before any individual nation, however remotely isolated geographically or commercially, could effectively guard its own citizens or residents against the introduction and distribution among them of the habit-forming narcotic drugs.

2. The Harrison Law was one of the Acts of Congress, enacted for the purpose of carrying out in good faith its international treaty obligations under The Hague Conven-

tion above-named. While technically a tax measure, the purpose and scope of the Harrison Law are such that it is in effect an excellent and desirable means of control by the government of the abuses incident to trade in the habit-forming narcotic drugs. There should be no ambiguity in the interpretation of its requirements by the medical profession, though under cover of the words, "in the course of his professional practice only," some have maintained that exemption is granted to physicians to prescribe or dispense the habit-forming narcotic drugs to addicts, alleging that they were so doing in an attempt to cure addiction; in reality, they were merely maintaining the addict in his customary use of narcotic drugs. Decisions of the courts thus far rendered have uniformly served to strengthen the obvious conclusion that such use of the professional privilege does not constitute proper professional practice.

3. There should be made an important modification of the law by Congress, to remove the tax burden on the medical profession (the annual tax for registration to permit physicians to prescribe certain habit-forming narcotic drugs was increased from $1 to $3, such increase having been excused at the time of the amendment of the law as a justifiable war-revenue measure, but unfortunately this remains still effective at the present time), which is imposed on physicians without compensatory return. Since the purpose of the Harrison Law is the interest of the public generally, and not taxation of physicians as a class, such class legislation is unfair to the medical profession as well as an unsound economic policy.

The amount of money collected under the Harrison Law during 1920, was $1,513,919.15, a sum far in excess of the amount appropriated by Congress for its enforcement. Furthermore, less than the amount appropriated was actually used in the operations for its enforcement during that year with a total field force of only 170 for the entire United States. To some extent, at least the reason for complaint that the Harrison Law has been ineffective, is obviously the failure to provide adequate funds and personnel for its enforcement, and to use such appropriations to their full extent. Since it was not intended that the Harrison Law should be a revenue producing measure, but that the registration fees of physicians licensed under this act should in part assist in defraying the cost of administration of the law, therefore, your committee recommends that the American

logical effects are such as to pre
their becoming of any importance a
drugs. The committee recommends
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ment of the Harrison Law as will
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which it is recognized as suitable
scribing other habit-forming narcoti

5. In view of the fact that enforc
laws is at present assigned to the s
Revenue Bureau of the federal g
charged with the enforcement of the
and since prohibition enforcement ne
appropriation of funds and a greater
a larger share of the public attenti
important duty of efficient enforcem
may be neglected. Therefore, your
that the American Medical Associati
by the Commissioner of Internal Rev
commissioner in charge of a separa
ment of the narcotic law, and that d
to that service in the accomplishme
tioning.

6. Your committee recommends tha
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harmony with and supplemental to t
shall base their control of any me
drugs on those powers possessed by t
as well as to revoke the license to
tistry, pharmacy or veterinary medic

The committee recommends that it
the appointment of committees by or

authorized to request the appointment of a Committee on Uniform State Narcotic Law by the National Conference of Commissioners on Uniform State Laws, and to cooperate with such committees, when appointed, in the preparation of such a law; it further recommends that state narcotic laws should follow the general principles set forth below:

A model state law need not be a tax law; and in fact, the taxing feature should be abolished. Its clear purpose, like that of the federal statute, should be definitely the control of distribution of the narcotic drugs, limiting to the utmost every possible abuse, while conserving the absolute right and duty of the practitioner to exercise his judgment regarding their proper use in the lawful practice of his profession. Such state law should closely follow, and not in any way conflict with the provisions of the federal law of paramount authority. The regulations and details of administration under the two laws should, therefore, be parallel, in order to avoid confusion and to facilitate compliance therewith; and the machinery of enforcement of a state law should be as simple as possible consistent with effective operation.

Unnecessary duplication of records under the federal and state laws should be eliminated, the state accepting the records kept under the Harrison Law.

Power to make and enforce special regulations of any sort, except those absolutely necessary in administrative application of the law, should not be entrusted to state officials. Those regulations considered necessary should be submitted for approval, before being promulgated, to the State Medical Board or other professional body of competent jurisdiction, and to the Attorney-General of the state.

A state law should embrace recognition of the clear purpose and intent of the Harrison Law, evidenced by the words, "in the course of his professional practice only," to prohibit distribution of narcotic drugs through physicians prescribing or dispensing them to addicts for self-administration, under the guise of administering the so-called "ambulatory reductive method of treatment" (since such method does not constitute treatment in good faith, nor has it the sanction of professional practice). Such proper control should be the basis of both state and federal laws. This intent ought to be clearly defined in a state law, i. e., by definitely prohibiting the "ambulatory treatment" of addiction, either by the private physician, or in institutions such as the so-called "narcotic clinic."

Unlawful possession of narcotic drugs should be made "prima facie evidence" of violation of the narcotic law, as in the Harrison Law.

Legal commitment of addicts on their own application, as well as their penal commitment, should be made equally effective in order to insure complete control of them while under treatment for the cure of their addiction.

Provision should be made by the state law for the treatment of those addicted to the use of narcotic drugs, in suitable institutions, existing or proposed for that purpose, or by private physicians, in either case, under the most rigid regulations.

Institutional care and treatment of addicts unable to pay for such care and treatment should be provided for through a state law. In case special institutions are provided for this purpose by the state, the industrial colony plan will approach nearest to the ideal solution of that problem.

All institutions should be required to maintain complete records and make annual reports to the State Department of Health, including all items called for by that body.

Administrative provisions of the narcotic laws in each state should be assigned properly to the State Department of Health, or to a special bureau under its jurisdiction. The department of health in each state should be clothed with plenary police powers in dealing with narcotic addiction as a menace to the public, as power is vested in it for the control of communicable diseases. Public sentiment should demand their effective application.

Penalty for violation of the narcotic laws, or narcotic addiction on the part of a physician, dentist, veterinary surgeon, nurse, druggist, or other practitioner, should include suspension or revocation of the license to practice his, or her, profession, in addition to the legal penalty for the criminal offense imposed by the court, on legal proof of such violation or addiction.

7. Your committee is of the opinion that a study of the need for habit-forming narcotic drugs in the practice of medicine should be undertaken and pursued through the channels of the organized medical profession, as well as by the federal and state authorities. On the basis of such study, it may be determined whether or not the necessity exists, for the limitation of the amount of narcotic drugs imported, manufactured or prepared in the United States. It is the unanimous opinion of the committee that there is, at present, no available data on which could be based any practical

plan for limiting imports, or for establishing a government monopoly in the importation, manufacture, preparation and distribution of the habit-forming narcotic drugs (if such plan could be legally adopted by the government, except by an amendment to the Constitution of the United States); and further, that such study could attain results of value, only after a considerable period of years, or when the members of the medical profession shall have been educated to supply accurate records of their actual needs for these drugs in the treatment of disease and the relief of pain and suffering.

8. Your committee desires to place on record its firm conviction that any method of treatment for narcotic drug addiction, whether private, institutional, official or governmental, which permits the addicted person to dose himself with the habit-forming narcotic drugs placed in his hands for self-administration, is an unsatisfactory treatment of addiction, begets deception, extends the abuse of habit-forming narcotic drugs, and causes an increase in crime. Therefore, your committee recommends that the American Medical Association urge both federal and state governments to exert their full powers and authority to put an end to all manner of such so-called ambulatory methods of treatment of narcotic drug addiction, whether practised by the private physician or by the so-called "narcotic clinic" or dispensary.

In the opinion of your committee, the only proper and scientific method of treating narcotic drug addiction is under such conditions of control of both the addict and the drug, that any administration of a habit-forming narcotic drug must be by, or under the direct personal authority of the physician, with no chance of any distribution of the drug of addiction to others, or opportunity for the same person to procure any of the drug from any source other than from the physician directly responsible for the addict's treatment.

9. Your committee recommends, in view of the fact that habit-forming narcotic drugs have definite, valuable and indispensable uses in the practice of medicine, there should be permitted no encroachment on the right and duty of the physician to exercise his judgment unhampered in the legitimate use of such narcotic drugs. Therefore, your committee recommends that the bills now before Congress which propose to limit the total amount of narcotic drugs which may be imported into the United States be disapproved, and their passage opposed by the American Medical Association, for the reason that such limitation, at the present time, would inevitably make these drugs more expensive and difficult to

obtain for proper medical purposes; and that such limitation of the total supply would certainly encourage smuggling of habit-forming narcotic drugs into the United States.

10. Your committee also recommends that the several state and county medical societies, constituent to the American Medical Association, be urged to obtain on their own initiative and through their own officers, such information as may be necessary to bring about the effective prosecution by local, state and federal authorities, of that small number of the members of the medical profession who are now acting in violation of the federal or state narcotic laws.

Respectfully submitted by the Chairman, for the Committee on Narcotic Drugs:

HAVEN EMERSON, M.D., Chairman,
GEORGE A. MCCOY, M.D.,
THOMAS S. BLAIR, M.D.,
ALFRED C. PRENTICE, M.D.

APPENDIX C

STATE LAWS AUTHORIZING COUNTY AND CITY HOSPITALS

ALABAMA.—Laws 1915, 544: Counties may levy a tax for the purpose of erecting hospitals. County commissioners may vote money for them. Counties may vote bond issues for tuberculosis hospitals.

Laws 1919, 704: Cities may issue bonds for the erection of hospitals.

ARIZONA.—No laws.

ARKANSAS.—No laws.

CALIFORNIA.—Statutes 1907, 366: Counties may construct and maintain hospitals and levy taxes for the indigent sick.

General Laws 1915, 572: Cities of the first class (400,000) may erect hospitals and levy taxes therefor.

COLORADO.—Court Statutes 1914, 2331: Incorporated towns and cities may establish and maintain. No tax provided.

Counties may vote bond issues for hospitals for indigents.

CONNECTICUT.—County unit ignored. Bill authorizing bond issue for state infirmatory now pending.

DELAWARE.—Provides for almshouses only.

FLORIDA.—Has state tuberculosis sanatorium.

GEORGIA.—Laws 1910, 130: An act to provide that in counties having a population of 125,000 or over the power shall

be vested in the board of county commissioners, or in the ordinary in the event there is no such board, to grant or refuse permission to establish cemetaries, sanatoriums, hospitals and similar institutions, and to regulate and control the same, and to provide the conditions under which the same may be established and to provide when such institutions may be declared nuisances and to provide a penalty for the violation of this act, and for other purposes.

IDAHO.—Complete Statutes 1919, V. 1, 483: Cities or counties may provide hospitals for infectious diseases.

Complete Statutes 1919, V. 1, 1127: Municipal corporations may establish hospitals.

Complete Statutes 1919, V. 1, 976; County hospitals for indigent sick.

Laws 1919, 175: Tuberculosis hospitals. An enabling act for rural hospitals failed to pass at the last legislature.

ILLINOIS.—Statutes Annual V 1, 954: Cities and towns may erect and establish hospitals.

Statutes Annual V. 2, 1231: May levy a tax not to exceed 3 mills on all taxable property in the city.

Call Annual Laws 1913-1916, 254: Further organization.

Call Annual Laws 1917-1920, 325: Tax raised to 3⅓ mills.

Section 135-155, Revised Statutes: Authorize the erection of county tuberculosis hospitals, in which cities and counties may join.

INDIANA.—Burns Annual Statutes 1914, V. 4, 250: Every city may establish and maintain hospitals. No tax specified.

Burns Annual Statutes 1914, V. 4, 407: May levy a tax not exceeding 7 cents on each $100 valuation of taxable property of such city.

Counties singly or in combination with other counties may erect and maintain hospitals and may vote bond issues.

IOWA.—Iowa Section 409, Revised Statutes: Authorize counties to vote bond issue to erect and maintain county hospitals.

KANSAS.—General Statutes, Annual 1915, 232: Cities may establish and regulate hospitals.

General Statutes, Annual 1915, 367: May procure land for such purposes. Cities between 6,000 and 10,000 may levy tax of 0.3 mill on the dollar of taxable property of such city. Cities between 3,000 and 6,000 may levy a tax of 1 mill.

General Statutes, Annual 1915, 571: Organizations and regulation of county hospitals. Manner of submitting proposition and levy of tax.

Laws 1917, 152: Cities between 3,000 and 6,000 may establish, acquire site for, build and maintain public hospitals and may levy in addition to other taxes prescribed by law, a tax

therefor, elect hospital trustees, maintain training school for nurses, and the trustees may provide the regulations and rules for operating, managing and conducting the hospitals.

Laws 1919, 218: Counties less than 40,000 may establish and maintain hospitals and levy a tax of 2 mills therefor.

KENTUCKY.—Laws 1920, 21: Counties containing cities of second and third class may establish county hospitals and issue bonds and levy taxes for construction and maintenance of same. Also provides for nurses' training schools.

LOUISIANA.—No laws.

MAINE.—No laws.

MARYLAND.—No laws.

MASSACHUSETTS.—Laws 1911, 621: Act to encourage building of tuberculosis hospitals by cities. Amended. Acts 1912, 691, Acts 1916, 177.

Laws 1913, 99: Subsidies to cities for establishing and maintaining tuberculosis hospitals.

Laws 1915, 126: Cities may establish and maintain hospitals.

MICHIGAN.—Complete Laws 1915, V. 3, 3876: Counties may maintain hospitals and may levy tax of 2 mills. Amended Public Acts 1917, 491, 504.

Public Acts 1919, 57: The tax shall not exceed 0.2 mill on each dollar.

MINNESOTA.—General Statutes 1913, 353: Cities of more than 10,000 and not more than 20,000 may acquire, own and operate hospitals. No tax provided.

Laws 1915, 373: Counties may establish and maintain county tuberculosis sanatoriums.

Laws 1917, 460: Counties of 25,000 may appropriate money for aid of county hospitals.

Laws 1919, 52: Cities of more than 50,000 may levy a tax of 1 mill for maintaining a hospital.

MISSISSIPPI.—Hem. Annual Code 1917, V. 2, 1923: Counties may establish hospitals for persons suffering with pellagra. They may provide charity wards in any hospital in their respective counties.

MISSOURI.—Laws 1915, 201: Counties may establish tuberculosis hospitals. May issue bonds.

Revised Statutes 1919, V. 3, 1021: Tuberculosis sanatorium.

NEBRASKA.—No laws.

NEVADA.—No laws.

NEW HAMPSHIRE.—Public Statutes 1901, 165: Towns may appropriate money to incorporated hospitals and $300 annually or $5,000 for permanent free hospital bed.

NEW JERSEY.—Complete Statutes 1910, V. 1, 1222: Cities shall have power to build, acquire and maintain hospitals.

Complete Statutes 1910, V. 2, 2750: Establishment and maintenance of county hospitals.

Complete Statutes 1910, V. 2, 2759: Establishment and organization of hospitals in cities and towns.

NEW MEXICO.—No laws.

NEW YORK.—Con. Laws Ed. 2, V. 3, 3316: Any town, city or village may acquire a hospital and levy tax for same. Organization and management. Counties of 35,000 or over must, and counties under 35,000 may, erect and maintain tuberculosis hospital.

NORTH CAROLINA.—Greg. Supp. to Pell's Rev. 1913, V. 3, 173: Establishment of county hospitals.

Laws 1917, 543: Towns and townships may also establish hospitals.

NORTH DAKOTA.—Complete laws 1913, V. 1, 861: Cities may erect and establish hospitals and control and regulate the same.

OHIO.—General Code 1, 1116: Counties may establish tuberculosis hospitals.

Laws 1919, 1055: Funds and management of county tuberculosis hospitals.

OKLAHOMA.—Revised Laws 1910, V. 1, 156: Cities of 2,000 may acquire, own and maintain hospitals and levy tax for same.

Laws 1919, 386: Counties may purchase sites and erect hospitals and may call for an election to vote bonds.

OREGON.—Counties may erect and maintain tuberculosis hospitals.

PENNSYLVANIA.—Any county and any city of third class in that county may erect a joint hospital. May issue bonds for such purpose. Counties may erect and maintain contagious disease hospitals.

RHODE ISLAND.—Laws 1917-1918, 347: Towns may appropriate money for use of hospitals.

SOUTH CAROLINA.—Laws 1916, 1169: Enabling Orangeburg County to establish and maintain a hospital and to provide a tax for the same.

Laws 1917, 640: Enabling Spartanburg County to establish and maintain a hospital and to provide a tax for the same.

SOUTH DAKOTA.—Laws 1919, 327: Authorizing counties to establish, erect and maintain county hospitals and to issue bonds for same.

TENNESSEE.—Bald. Cum. Code Supp. 1920, 313: County courts may establish tuberculosis hospitals and raise funds for maintenance.

TEXAS,—Complete stats. 1920, 284: Power of commissioners court to establish or enlarge county hospitals; petition of voters; issue of bonds.

UTAH.—Comp. laws 1917, 381: Counties may erect hospitals.

Laws 1917, 371: Counties may establish and maintain hospitals, levy taxes and issue bonds, elect hospital trustees and maintain training schools for nurses.

Laws 1919, 128: Maternity hospitals under supervision of board of health.

VERMONT.—Gen. laws 1917, 685: Towns may appropriate money for support of nonsectarian hospitals.

Laws 1919, 108: Towns may make appropriations to hospitals for free beds.

VIRGINIA.—Rem. codes and stats. 1915, V. 2, 2849: Counties and towns may establish hospitals.

WASHINGTON.—Code 1919, 507: Cities of first and second classes may erect and establish hospitals.

WEST VIRGINIA.—No laws.

WISCONSIN.—Stats. 1917, 826: Explains power and authority of governing board of municipal hospitals.

WYOMING.—Laws 1917, 100: Counties may aid, establish and maintain memorial county hospitals.

The following states do not have any city or county hospital law although some of them provide for tuberculosis sanatoriums:

Arkansas, Arizona, Connecticut, Delaware, Florida, Louisiana, Maine, Maryland, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, Ohio, Oregon and West Virginia.

APPENDIX D

TEXT OF THE IOWA LAW FOR COUNTY PUBLIC HOSPITALS

SEC. 409. (*a*) Public Hospital; proceedings for establishment of; any county may establish a public hospital in the following manner: Whenever the board of supervisors of any county shall be presented with a petition signed by two hundred resident free holders of such county one hundred fifty of whom shall not be residents of the city, town or village where it is proposed to locate such public hospital, asking that an annual tax may be levied for the establishment and maintenance of a public hospital at a place in the county named therein and shall specify in their petition the maximum amount of money proposed to be expended in purchasing or building said hospital

such board of supervisors shall submit the question to the qualified electors of the county at the next general election to be held in the county, or at a special election called for that purpose, first giving ninety days' notice thereof in one or more newspapers published in the county, if any be published therein and by posting such notice, written or printed in each township of the county, which notice shall include the text of the petition and state the amount of tax to be levied upon the assessed property of the said county, which tax shall not exceed 2 mills on the dollar, for a period of time not exceeding twenty years, and be for the issue of county bonds to provide funds for the purchase of a site or sites and erection thereon of a public hospital and hospital buildings, and for the support of same; which said election shall be held at the usual places in such county for electing county officers, the vote to be canvassed in the same manner as that for county officers. (33 G. A., Ch. 26, No. 1.)

SEC. 409. (*b*) Question submitted; hospital fund. The board of supervisors of such county shall submit to the qualified electors thereof, at a regular or special election, the question whether there shall be levied upon the assessed property of such county a tax of —— mills on the dollar for the purchase of real estate for hospital purposes, for the construction of hospital buildings and for maintaining same, or for either or all of such purposes. The ballots to be used at any election at which the hospital question is submitted shall be printed with a statement substantially as follows:

YES For a —— mill tax for a bond issue for a public
NO hospital and for maintenance of same.

If a majority of the votes cast at such election on the proposition so submitted shall be in favor of a —— mill tax for a bond issue for a public hospital and for maintenance of same, the board of supervisors shall levy the tax so authorized, which shall be collected in the same manner as other taxes are collected and credited to the "hospital fund" and shall be paid out on the order of the hospital trustees for the purposes authorized by this act, and for no other purposes whatever. (33 G. A., Ch. 26, No. 2.)

SEC. 409. (*c*) Board of Hospital Trustees; term. Should a majority of all the votes cast upon the question be in favor of establishing such county public hospital, it is made mandatory that the board of supervisors shall proceed at once to appoint seven trustees chosen from the citizens at large with reference to their fitness for such office, three of whom may be women, all residents of the county, not more than four of said trustees to be residents of the city, town or village in which said hospital is to be located, who shall constitute a board of trustees of said public hospital. The said trustees

shall hold their offices until the next following general election, when seven hospital trustees shall be elected and hold their offices, two for two years, two for four years, three for six years, and who shall by lot determine their respective terms. At each subsequent general election, the offices of the trustees whose term of office are about to expire shall be filled by the nomination and election of hospital trustees in the same manner as other officers are elected, none of whom shall be practicing physicians. (33 G. A., Ch. 26, No. 3.)

SEC. 409. (*d*) Organization of board; treasurer; expense of trustees; powers and duties. The said trustees shall within ten days after their appointment or election qualify by taking the oath of civil officers, and organize as a board of hospital trustees by the election of one of their number as chairman, one as secretary, and by the election of such other officer as they may deem necessary; but no bond shall be required of them. The county treasurer of the county in which such hospital is located shall be treasurer of the board of trustees. The treasurer shall receive and pay out all moneys under the control of the said board as ordered by it, but shall receive no compensation from such board. No trustee shall receive any compensation for his service performed, but he may receive reimbursement for any cash expenditures actually made for personal expenses incurred as such trustee, and itemized statement of all such expenses and money paid out shall be made under oath by each of such trustees and filed with the secretary, and allowed only by the affirmative vote of all the trustees present at a meeting of the board. The board of hospital trustees shall make and adopt such by-laws, rules and regulations for their own guidance and for the government of the hospital as may be deemed expedient for the economical and equitable conduct thereof, not inconsistent with this act and the ordinance of the city or town wherein such public hospital is located. They shall have the exclusive control of the expenditure of all moneys collected to the credit of the hospital fund, and of the purchase of site or sites, the purchase or construction of any hospital building or buildings, and of the supervision, care and custody of the grounds, rooms or building purchased, constructed, leased or set apart for that purpose; provided that all moneys received for such hospital shall be deposited in the treasury of the county to the credit of the hospital fund, and paid out only upon warrants drawn by the auditor of said county upon the properly authenticated vouchers of the hospital board. Said board of hospital trustees shall have power to appoint a suitable superintendent or matron, or both, and necessary assistants, and fix their compensation, and shall also have the power to remove such appointees; and shall in general carry out the spirit and intent of this act in establishing and maintaining a county public

hospital, with equal rights to all and special privileges to none. Such board of hospital trustees shall hold meetings at least once each month, shall keep a complete record of all its proceedings, and four members of said board shall constitute a quorum for the transaction of business. One of said trustees shall visit and examine said hospital at least twice each month, and the board shall, during the first week of January of each year, file with the board of supervisors of said county a report of their proceedings with reference to such hospital, and a statement of all receipts and expenditures during the year. No trustee shall have a personal pecuniary interest either directly or indirectly in the purchase of any supplies for said hospital, unless the same are purchased by competitive bidding. (33 G. A., Ch. 26, No. 4.)

SEC 409. (*f*) Hospital bonds. Whenever any county in this state shall have provided for the appointment and election of hospital trustees and have voted a tax for a term not exceeding twenty years for hospital purposes, as authorized by law, the said county may issue bonds in anticipation of the collection of such tax, in such sums and amounts as the board of hospital trustees shall certify to the board of supervisors of said county to be necessary for the purposes contemplated by such tax, but such bonds in the aggregate shall not exceed the amount which might be realized by said tax based on the amount which may be yielded on the property valuation the year in which the tax is voted, and such bonds shall mature in twenty years from date, and shall be in the sum of not less than $100 nor more than $1,000, drawing interest at a rate not exceeding 5 per cent. per annum, payable annually or semi-annually; said bonds shall be payable at pleasure of county after five years, and each of said bonds shall provide that it is subject to this condition, and shall not be sold for less than par, and shall be substantially in the form provided for county bonds, but subject to changes that will conform them to the provisions of this act, and be numbered consecutively and redeemable in the order of their issuance. For the negotiation of said bonds, their constitutionality, levy to pay interest and principal and redemption, Sections 403, 404 to 409, inclusive, of Chapter 1, Title 4 of the Code shall apply; provided the total amount of bonds to be issued shall not exceed $100,000. (33 G. A., Ch. 26, No. 6.)

SEC. 409. (*g*) Condemnation proceedings for hospital sites. If the board of hospital trustees and the owners of any property desired by them for hospital purposes cannot agree as to the price to be paid therefor, they shall report the fact to the board of supervisors, and condemnation proceedings shall be instituted by the board of supervisors and prosecution in the name of the county wherein such public hospital is to be

located, by the county attorney for such county, under the provisions of Chapter 4 of Title 10 of the Code. (33 G. A., Ch. 26, No. 7.)

SEC. 409. (*h*) Plans and specifications; bids advertised for. No hospital buildings shall be erected or constructed until the plans and specifications have been made therefor and adopted by the board of hospital trustees and bids advertised for according to law for other county public buildings. (33 G. A., Ch. 26, No. 8.)

SEC. 409 (*i*) Municipal jurisdiction. The jurisdiction of the city, town or village in or near which public hospital is located shall extend over all lands used for hospital purposes outside the corporate limits, if so located, and all ordinances of such cities and towns shall be in full force and effect in and over the territory occupied by such public hospital. (33 G. A., Ch. 26, No. 9.)

SEC. 409. (*j*) Annual levy for improvement and maintenance. That section ten of chapter twenty-six of the acts of the thirty-third general assembly be, and the same is hereby, repealed, and the following is enacted in lieu thereof:

"In the counties exercising the rights conferred by this act, the board of trustees of said hospital shall, at its regular August meeting each year, determine and fix the amount necessary for the improvement and maintenance of any such public hospital so established during the ensuing year. In addition to the tax for the hospital fund hereinbefore provided for, and the president and secretary of the board shall certify the same to the county auditor of such county before September first of each year; and the Board of Supervisors of said county shall at its September session following levy a sufficient tax upon the assessed value of the taxable property in the county as will produce said sum for the ensuing year, but said levy shall not exceed one mill on such assessed valuation." (35 G. A., Ch. 39, No. 1; 33 G. A., Ch. 26, No. 10.)

SEC. 409. (*j*-1) Acts in conflict repealed. All acts and parts of acts conflict with this act and provision are hereby repealed. (36 G. A., Ch. 26, No. 39.)

SEC. 409 (*k*) Who entitled to hospital benefits—compensation—nonresidents. Every hospital established under this act shall be for the benefit of the inhabitants of such county and of any person falling sick or being injured or maimed within its limits; but every such inhabitant or person who is not a pauper shall pay to such board of hospital trustees or such officer as it shall designate for such county public hospital, a reasonable compensation for occupancy, nursing, care, medicine or attendance, according to the rules and regulations prescribed by said Boards, such hospital always being subject to such reasonable rules and regulations as said board may adopt in

order to render the use of said hospital of the greatest benefit to the greatest number, and said board may exclude from the use of such hospital any and all inhabitants and persons who shall wilfully violate such rules and regulations. And said board may extend the privileges and use of such hospital to persons residing outside of such county upon such terms and conditions as said board may from time to time by its rules and regulations prescribe. (33 G. A. Ch. 26, No. 11.)

SEC. 409. (*l*) Exclusive control by trustees. When such hospital is established, the physicians, nurses, attendants, the persons sick therein and all persons approaching or coming within the limits of same, and all furniture and other articles used or brought there shall be subject to such rules and regulations as said board may prescribe. (33 G. A. Ch. 26, No. 12.)

SEC. 409. (*m*) Donations to hospital—title vested in county. Any person or persons, firm, organization, corporation or society desiring to make donations of money, personal property or real estate for the benefit of such hospital, shall have the right to vest the title of the money or real estate so donated in said county, to be controlled when accepted, by the Board of Hospital Trustees according to the terms of the deed, gift, devise or bequest, of such property. (33 G. A. Ch. 26, No. 13.)

SEC. 409. (*n*) Medical practitioners—no discrimination—right of patient to employ. In the management of such public hospital, no discrimination shall be made against practitioners of any school of medicine recognized by the laws of Iowa, and all such legal practitioners shall have equal privileges in treating patients in said hospital. The patient shall have the absolute right to employ at her or his own expense, his or her own physician, and when acting for any patient in such hospital the physician employed by such patient shall have exclusive charge of the care and treatment of such patient, and nurses therein shall as to such patient be subject to the directions of such physician; subject always to such general rules and regulations as shall be established by the Board of Trustees under the provision of this act. (33 G. A. Ch. 26, No. 14.)

SEC. 409. (*o*) Training School for Nurses. The Board of Trustees of such county public hospital may establish and maintain in connection therewith and as a part of said public hospital a training school for nurses. (33 G. A., Ch. 26, No. 15.)

SEC. 409. (*p*) Detention and examination of insane. The said board of trustees shall at all times provide a suitable place for the detention and examination of all persons who are brought before the commissioners of insanity for such county, provided that such public hospital is located at the county seat. (33 G. A. Ch. 26, No. 16.)

SEC. 409. (*q*) That section four hundred nine-q (409-q) be and the same is hereby amended by striking out all the said section and enacting in lieu thereof the following: "That the Board of Trustees of any hospital, either operating now, or in process of construction, or to be established in the future under this act is hereby authorized to operate said hospital as a tuberculosis sanatorium if deemed advisable or to provide as a department of said public hospital suitable accommodations and means for the care of persons afflicted from tuberculosis. That said Board of Trustees may also establish as a department of said county hospital a suitable building or buildings for the isolation or detention of persons afflicted with contagious diseases and who are subject to the quarantine regulations of the state board of health. That said Board of Trustees may formulate such rules and regulations for the government of such persons and the protection from infection or other patients and nurses and attendants in such public hospital as they may deem necessary, and it shall be the duty of all persons in charge of or employed in such hospitals or residents thereof to faithfully obey and comply with any or all such rules and regulations.

SEC. 409. (*r*) Compensation for treatment—subject for charity. The Board of Hospital Trustees shall have power to determine whether or not patients presented at such public hospital for treatment are subjects for charity, and shall fix such price for compensation for patients, other than those unable to assist themselves, as the said board deems proper, the receipts therefor to be paid to the treasurer of said county and credited by him to the hospital fund. (33 G. A., Ch. 26, No. 18.)

SEC. 409. (*s*) Indigent tuberculosis patients—with other hospitals. The Board of Supervisors of any county where no suitable provision has been made for the care of its tuberculous residents, who are financially unable to care for themselves, may contract with the Board of Hospital Trustees of any public hospital for the care of such persons in the sanatorium of said hospital upon such reasonable terms as may be agreed upon. That any person suffering with tuberculosis who shall persistently or carelessly or maliciously expectorate the matter coughed up from his lungs and who refuses to properly protect the public or persons with whom he may be associated, against the dangers of infection, then such persons may be tried as provided in Section 2310-a2, Title 12, Chapter 2-A of the supplement to the code 1913, and upon conviction may by the District Court be committed to the State Sanatorium, subject to the laws of admission at said institution, or any county sanatorium or other institution where tuberculosis is cared for. Provided that such careless consumptive shall in no case be sent to any such institution

until the committee officer shall first have made inquiry and ascertained that the institution to which said careless consumptive is to be sent has proper quarters, and is properly prepared and ready to take care of such case and only after the legal application blanks and procedures are properly completed and carried out. That if any patient being treated for tuberculosis at the State Sanatorium, or any county sanatorium or other institution where tuberculosis is cared for shall refuse to comply with the laws of the state and rules and regulations for the government of the institutions named herein, and shall persistently or carelessly or maliciously violate such laws, rules and regulations so as to menace the welfare of said institutions or to interfere with the administration, order or peace of said institution, then upon complaining of the superintendent of any institution herein designated, such person can by order of the district court be segregated and forcibly detained in a ward or room for such purpose and such period of time as may be deemed advisable in a ward or room for such purposes and for such period of time as may be deemed advisable by the court to the end that such person may be properly treated, that the population of such institution may be protected and the decorum maintained.

SEC. 409. (*t*) Care of Charity Patients in advanced stages of tuberculosis—expenditure limited. That the Board of Supervisors of each county in this state is hereby authorized to provide for the separation and maintenance of persons financially unable to provide for themselves who have no relatives liable for their support and who are suffering from pulmonary tuberculosis farther advanced than the incipient stages. Such provision may be made by constructing or otherwise securing and equipping suitable buildings and operating them, or placing the person designated in institutions designed and prepared to give them suitable care and treatment, and the board of supervisors may allow for the care and support of each patient in such institution a sum not exceeding fifteen dollars per week. Provided that in counties of fifteen thousand or over population, a sum not to exceed five thousand dollars, and in counties of less than fifteen thousand population a sum not to exceed two thousand dollars, may be appropriated for constructing, acquiring and equipping buildings without a vote of the qualified electors. The board of supervisors may submit the question of expending a greater amount than above specified to a vote for the people at any general election, and may for such purposes expend the amount by said vote authorized. (35 G. A. Ch. 40, No. 1.)

SEC. 409. (*u*) That Title four (4), Chapter two (2) of the supplement to the code 1913 be and the same is hereby amended by addition to said chapter as Section four hundred

nine-u (409-u) the following: "That hospitals either operating now or in process of construction or to be established hereafter under this act instead of being called 'County Public Hospital' may be named by the use of some appropriate 'title' or 'appellation.' "

SEC. 409. (*v*) All acts or parts of acts not in harmony with the provisions of this act are hereby amended to conform with this act.

SEC. 409. (*t*-1) Care of charity patients in advanced stages of tuberculosis—expenditures limited—repealed. (36 G. A. H. F. 352, No. 4.)

SEC. 409. (*t*-2) Board of supervisors to provide care for the indigent tuberculous persons. That the Board of Supervisors of each county in this state shall provide for suitable care and treatment of persons suffering from tuberculosis and who are financially unable to provide for themselves and who have no relative liable for their support. (36 G. A. H. F. 352, No. 1.) (35 G. A. Ch. 40, No. 1.)

SEC. 409. (*t*-3) That Section four hundred nine-t-3 (409-t-3) supplemental supplement to the code, 1915, be and the same is hereby repealed and the following enacted in lieu thereof: That in compliance with the provisions of Section 409-t1 and Section 409-t2, supplemental to the code 1915, the board of supervisors may arrange in said county, or elsewhere in the state, with any institution maintained for the treatment of tuberculosis, or with a county public hospital, or any other hospital not maintained for pecuniary profit, where sutiable facilities may be provided, and said board of supervisors is authorized to construct or otherwise provide and equip suitable buildings in connection with such institution, or hospital if in the county, for the proper segregation and maintenance of such designated persons; provided, however that no institution, or hospital, or building for the care and treatment of persons afflicted with tuberculosis shall be established at any county home in this state. And it is further provided that any institution, hospital or place for the treatment of persons afflicted with tuberculosis now established, or which may be established in the future, shall be approved by the board of control and inspected by said board. And said board shall have the power to require any alterations in building or equipment or changes in treatment that may be necessary to make such institution conform to the modern and accepted methods for the treatment of tuberculosis.

SEC. 409. (*t*-4) Allowance for support; appropriation for buildings; election authorizing greater expenditure. The board of supervisors shall allow for the care and support of each patient when in such designated institution, a sum not exceeding $15 per week from the poor fund; provided, that in

counties of 67,000 a sum not to exceed $5,000, and in counties of less than 15,000 population a sum not to exceed $2,000 may be appropriated out of the county funds for constructing, acquiring and equipping buildings without submitting the same to a vote of the qualified electors. The board of supervisors may submit the question of expending a greater amount than above specified by a vote of the qualified electors of the county at any general election and may for such purposes expend the amount authorized by said vote. (36 G. A., H. F. 352.)

SEC. 409. (*s*) Indigent tuberculous patients; contracts with other hospitals. The board of supervisors of any county where no suitable provision has been made for the care of its tuberculous residents, who are financially unable to care for themselves may contract with the board of hospital trustees of any public hospital for the care of such persons in the sanatorium of said hospital upon such reasonable terms as may be agreed upon; that any person suffering with tuberculosis who shall persistently, carelessly or maliciously expectorate the matter coughed up from his lungs, and who refuses to properly protect the public or persons with whom he may be associated against the dangers of infection, then such person may be tried as provided in Section 2310-*a2*, Title 12, Chapter 2-A of the Supplement to the Code, 1913, and upon conviction may, by the district court, be committed to the state sanatorium, subject to the laws of admission at said institution, or any county sanatorium or other institution where tuberculosis is cared for; provided, that such careless consumptive shall in no case be sent to any such institution until the committing officer shall first have made inquiry and ascertained that the institution to which such careless consumptive is to be sent has proper quarters and is properly prepared and ready to take care of such cases, and only after the legal application blanks and procedures are properly completed and carried out; that if any patient being treated for tuberculosis at the state sanatorium, or any county sanatorium or other institution where tuberculosis is cared for, shall refuse to comply with the laws of the state and rules and regulations for the government of the institutions named herein and shall persistently, or carelessly or maliciously violate such laws, rules and regulations, so as to menace the welfare of said institutions, or to interfere with the administration, order or peace of said institution, then upon complaint of the superintendent of any institution herein designated, such persons can by order of the district court be segregated and forcibly detained in a ward or room for such purposes and for such period of time as may be deemed advisable by the court to the end that such person may be properly treated, that the population of such institution may be protected and the decorum maintained.

SEC. 409. (*t*) Care of charity patients in advanced stages of tuberculosis; expenditures limited. That the board of supervisors of each county in this state is hereby authorized to provide for the separation and maintenance of persons financially unable to provide for themselves, who have no relatives liable for their support, and who are suffering from pulmonary tuberculosis farther advanced than the incipient stage, such provisions may be made by constructing or otherwise securing and equipping suitable buildings and operating them or by placing the persons designated in institutions designed and prepared to give them suitable care and support of each patient in such institution and appropriating a sum not exceeding $15 per week; provided that in counties of 15,000 population or over, a sum not to exceed $2,000 may be appropriated for constructing, acquiring and equipping buildings without a vote of the qualified electors. The board of supervisors may submit the question of expending a greater amount than above specified to a vote of the people at any general election, and may for such purposes expend the amount by said vote authorized. (35 G. A,. Ch. 40, No. 1.)

SEC. 409. (*u*) That Title 4, Chapter two (2) of the Supplement to the Code, 1913, be and the same is hereby amended by addition to said chapter as Section four hundred and nine-*u* (409-*u*) the following: "That hospitals either operating now or in process of construction or to be established hereafter under this act, instead of being called county public hospital, may be named by the use of some appropriate title or appellation."

SEC. 409 (*v*) All acts or parts of acts not in harmony with the provisions of this act are hereby amended to conform to this act.

APPENDIX E

TEXT OF THE MICHIGAN LAW ON TEACHING DISEASE PREVENTION IN THE PUBLIC SCHOOLS

An Act to Provide for Teaching in the Public Schools the Modes by Which the Dangerous Communicable Diseases Are Spread and the Best Methods for the Restriction and Prevention of Such Diseases.

The people of the State of ..... enact:

(153) 5807. SECTION 1. There shall be taught in every year in every public school in ..... the principal modes by which each of the dangerous communicable diseases are spread and the best methods for the restriction and prevention of each such diseases. Such instruction shall be given by the aid of text-books on physiology, supplemented by oral and black-board instructions. From and after 1900

Dangerous communicable diseases subject taught in public schools

no text-book on physiology shall be adopted for use in the public schools of this state, unless it shall give at least one-eighth of its space to the cause and prevention of dangerous communicable diseases. Text-books used in giving the foregoing instruction shall before being adopted for use in the public schools have that portion given to the instruction in communicable diseases approved by the state board of health to the state board of education.

Textbooks, approval of

(154) 5808. SEC. 2. Neglect or refusal on the part of any superintendent or teacher to comply with the provisions of this law shall be considered a sufficient cause for dismissal from the school by the school board. Any school board wilfully neglecting or refusing to comply with any of the provisions of this act shall be subject to fine the same as for neglect of any other duty pertaining to their office. This act shall apply to all schools in this state, including schools in cities or villages, whether incorporated under special charter or under general laws.

Penalty for neglect or refusal to comply

Report of the Council on Medical Education and Hospitals

To the Members of the House of Delegates of the American Medical Association:

Since 1904, when the Council on Medical Education was created, one of its most effective methods of procedure has been the conducting of an annual conference on medical education. The first conference was held in 1905 in Chicago where the conference has been held each year since that time. To these annual conferences have been invited representatives of medical schools, universities, state licensing boards, government medical services, educational foundations and others interested in medical education. These annual conferences have profoundly influenced medical education in this country. In no other field of education in this country have such great advances been made as in medical education in the last fifteen years.

COUNCIL'S WORK MERELY BEGUN

The task undertaken in 1905—the securing of uniform and acceptable standards—has in large part been completed. The accepted American standard is now two years of pre-medical work in an approved college or university, a four year medical curriculum and a year's internship in a hospital, forming as high a standard of medical requirements as that adopted by any other country. But a broad view of the situation shows that instead of being complete, our task has only begun. In New Orleans last year your honorable body added to the duties of the Council that of studying the hospitals of the United States. This increased function came naturally enough, since the addition of a hospital intern year to the medical curriculum had already made it necessary for the Council to investigate hospitals from the educational standpoint.

The work of the Council has grown to include a study of the problems of preliminary education; the undergraduate medical curriculum, the hospital in its relation to clinical teaching and the intern year; graduate medical education and provision for the training of specialists; the development of specialty group practice and the extent to which medical

practice is done in hospitals. With this expansion of the Council's work there has gradually grown in the minds of many of us the recognition of a large and complex problem and, whether we desire it or not, our duties have grown far beyond the original idea of merely elevating the standards of medical education. It has become clear that the efforts of the Council and of the organized profession to elevate the standards of medical education; to improve postgraduate medical work; to train specialists, and to improve hospital work, are all for the purpose of providing for the public the best possible facilities offered by modern scientific medicine for the diagnosis, cure and prevention of disease.

ORGANIZED MEDICINE PREFERABLE TO STATE MEDICINE

The possibilities of modern medicine are so great that, like education, it has become one of the great functions of modern civilization. The people of our country, rich and poor alike, are entitled to the great benefits of modern medicine and some plan should be devised to secure these for them. There has been much discussion regarding compulsory health insurance and state medicine. Fortunately for us, other countries have experimented with these methods and the results are not such as to encourage us to follow their example. As our knowledge of the situation has grown it has become more and more evident that these medical problems must be solved and the medical work done by the medical profession itself. In our democratic form of government the medical functions of the city, of the state and of the nation must be developed and carried on largely by those who are best qualified to do it—the medical men themselves. The American medical profession has a thoroughly democratic and representative organization in the American Medical Association, with its county and state medical societies. It covers the entire country and can be made to reach every community. The medical profession must be awake to its greater opportunities and responsibilities, which means the organization of the profession for further developing the practice of modern scientific medicine.

MANNER OF PROCEDURE

Is this to be accomplished by creating out of the medical profession a huge political machine which shall enter into every town, county and state and which shall enforce laws

providing for the medical care to all individuals? Not at all. It is not necessary to alter in any way our present laws or our present organization. The organized profession should simply recognize the fact that its most important function is to secure for all the public the benefits of modern medical practice and to develop intelligent practical plans to furnish the best medical service possible in each community. This program means a cooperation of the profession with the municipal, state and national authorities. It means an intelligent and energetic propaganda for the education of the people and the profession. It means the creation of a public opinion which will demand an efficient, sound, universal medical practice and it means providing the essential equipment.

GENERAL ADVANCEMENT MAKES CHANGES NECESSARY

The advancement in modern medicine during the last forty years has been so great in both the diagnosis and treatment of disease that the practice of medicine has been revolutionized. Forty years ago the practice of medicine was a comparatively simple matter. A general practitioner with good training and with little in the way of instruments and equipment—such as he could carry about with him from house to house, in his saddle bags or in his doctor's buggy—could give to his patients the benefit of the medical knowledge of his time. Today the practice of scientific medicine requires much more. It requires the services not only of the general practitioner but also of specialists trained in limited fields of diagnosis and therapy. It requires extensive plants, equipment and appliances, clinical laboratory facilities, X-ray laboratory facilities, facilities and equipment for employing diagnostic and therapeutic measures in the office, in the clinic and in the hospital. It requires an extensive public health organization to secure the benefits of preventive medicine.

IMPORTANCE OF GENERAL PRACTITIONERS

The development of this complex scheme has brought with it the necessity of educating two classes of medical men, the general practitioner and the specialist. The general practitioner is and will always remain the most important single factor in the practice of medicine. The profession should recognize this and realize that the most important function of our medical schools is to train well-qualified general prac-

titioners and that the undergraduate medical course should be planned with that end in view. The time has arrived when we must reorganize our course of medical study so as to give a broader and less specialized training to the men who graduate in medicine and who are to become general practitioners. The training of specialists should come later, such special preparation to be given to a limited number of men—10 per cent. or more of the practitioners of the community—who are to provide expert medical services in limited fields of practice. The undergraduate course in most medical schools is now being given by a group of specialists, each of whom endeavors to cover pretty fully his subject and to give his students a training in his special field. This is true of all departments. They forget the fact that the medical school cannot perform the impossible task of making expert anatomists, physiologists, ophthalmologists, or orthopedic surgeons, but they can make broadly trained general practitioners whose function is to take care of the ordinary illnesses and surgical emergencies, the obstetric work and the family practice in the communities in which they live. Too often medical faculties do not include teachers broadly trained in general medicine and general surgery, often the professor of obstetrics is a celebrated gynecologist who is emersed in operative work, who devotes the major part of his course to abdominal surgery and the cesarean sections, and who slights his real duty of training his students in the common every day obstetrics which they will need in actual practice.

REVISION OF UNDERGRADUATE CURRICULUM

The undergraduate medical course should be reorganized in several ways:

1. The student should begin clinical work much earlier in his course.

2. The anatomy and physiology and pathology and pharmacology taught should be the portions of these sciences which will be of service to the student in his clinical work. Anatomy and physiology should not be completed at the end of the second year but should be carried into the hospital and clinic.

3. The clinical work of the ten or more special departments should be simplified and given by the three departments, general medicine, general surgery and obstetrics. Whatever work is given in medical and surgical specialties should be

limited to the work required by the student as a general practitioner. The place of the specialist in medical education is in the graduate medical course and his function is the training of specialists. We must give to the position of the general practitioner the importance which it deserves in the whole medical scheme.

WORK OF THE GENERAL PRACTITIONER

To those who have followed the development of medical education and medical practice during the last twenty-five years and noted the great increase in the number of specialists, the overshadowing importance of the broadly trained practitioner in modern scientific practice has become more and more evident. For example, one medical man can take care of the general practice in a community of one thousand people. Ninety per cent. of the illnesses which occur in such a community are the ordinary things in practice—the colds, the infantile diseases, the pregnancies and abortions, the pneumonias and typhoids, the sore eyes and shingles, the broken arms, the epilepsies, the cases of insanity, the heart lesions, the cases of Bright's disease, the gallstone colics, and the cases of appendicitis, the hernias and hemorrhoids. All these cases can be better taken care of by a broadly trained general practitioner who lives in the community and who is always accessible, than they can possibly be by any scheme which employs specialists only. One of the most important functions of the well trained general practitioner is to decide when the services of a specialist are needed. This decision cannot be left to the patient nor to the patient's family; they are not competent to decide.

ADVANTAGES OF GENERAL PRACTICE

In his daily practice the general practitioner has a great and unique opportunity to study disease and to carry on clinical research of greater importance. He sees the complete picture of disease unroll before him. He sees its beginnings; he sees disease when it is most curable. He sees it to the end; he sees disease not only in the individual but also in the family and in the community in which he lives. The specialist does not get this broad and complete view. These facts need special emphasis at this time when is witnessing such an increase of specialism. One of our modernly trained internists said recently: "There is something wrong with our present scheme

of medical education. In the group of young men with whom I have trained there are no broadly trained men like Osler and Billings; we are each pursuing some narrow field of work and see nothing beyond that field."

FIELD FOR SPECIALISTS AND DANGERS

As to the specialist trained in a limited field of practice, *there is and there can be but one science of medicine. It cannot be subdivided into specialties;* it is not limited to the eye, the heart, the stomach or the ovary but covers the entire human body in health and in disease. The *art, or practice* of medicine, on the contrary can be and has been very properly divided into a number of the specialties, and with sound reason. The practice of medicine has become so extensive that no one man can master all its details. The division of practice into specialties enables a man to devote intensive study to a limited field, in which he can become expert in the use of special instruments and measures employed in diagnosis and therapy any by intensive research add to our knowledge of the diseases of that field. There are, however, great dangers in specialism. Unless specialists have a broad training and experience in general medicine as a foundation, they are not safe practitioners. They are apt to limit their observations and therapy to the findings in their special field and to overlook other abnormalities in the individual which may be the essential cause of his illness. The narrow specialist may do a great deal of artificial and unnecessary work and if uncontrolled may be a menace to his patients and to sound medical practice.

There are two safe plans for the practice of a specialty, first, by one who has obtained a broad view of medicine as well as the special training required in his limited field; second, by a specialist who, although he lacks the broad training of the general practitioner, acts as a member of a group well organized for group practice, so that patients referred to him have been first carefully examined by one who is broadly trained in general medicine, who acts as captain of the group; makes a diagnosis of the general condition of the patients; decides what cases require the services of this or that particular specialist, and who controls in a general way the diagnosis and therapy in the case. Some such general control is necessary in the safe practice of any specialty.

BETTER TRAINING OF SPECIALISTS NEEDED

The inspection of the graduate medical schools made by the Council last year revealed the fact that the graduate work being done in this country was entirely inadequate. It was found that many physicians began the practice of some specialty after a short graduate course of six weeks or less. It was noted that a very large number of these short course specialists were learning the technic of tonsillotomy and submucous resections. The Council was convinced by their investigations that it was exceedingly important for the American Medical Association to formulate some plan for the proper training of specialists.

MINIMUM TRAINING FOR SPECIALISTS

With that object in view, during the last year a committee of nine prominent specialists was appointed in each of the laboratory and clinical subjects of the medical curriculum and instructed to formulate a reasonable minimum requirement for men preparing to specialize in that particular field. Outlines of these plans were submitted to the annual conference last March. On the basis of these reports and the general discussion given to them, the Council submits the general plan of graduate training for specialists to the House of Delegates for its approval. If this plan is approved by the American Medical Association, outlines of the minimum requirements in each of the various specialties will then be submitted to twenty or more of our strongest universities having medical departments, with the request that they undertake to provide the required courses of graduate instruction. After such courses have been established, the state licensing boards may find it possible to restrict practice in the specialties to men who have received adequate training in their limited fields. The Council believes it is clearly the duty of the medical profession to protect the public against ill-trained and incompetent medical specialists by securing some such action by the universities and the state licensing boards.

A LARGE AND IMPORTANT TASK

The organization of medical practice by which the public may be benefited by the great possibilities of modern medicine is a problem which involves not only the education of the general practitioner and the specialist but also the establish-

ing of general hospitals, outpatient departments, special hospitals and group clinics, wherever they are needed. It includes also the proper training of nurses, proper public health service and all this work should be combined with the practice of medicine in the most effective way.

The solution of this problem will require the cooperation of many agencies; it will require much, time, imagination and hard work. If the organized medical profession in each state and in each county, recognizes and assumes this task as its most important and basic function; if the medical profession endorses, undertakes and carries on this work, it will be much better both for the public and the profession than to have the task assumed by the state and developed into some scheme of state medicine.

RECOMMENDATION

The Council would respectfully recommend that the American Medical Asssociation undertake the further organization of the medical profession of this country, so as to provide the benefit of modern medicine for all our people.

Other Work of the Council During the Year

The preceding part of the report sets forth the activities of the Council in the establishing of minimum standards of graduate training in the various specialties, reports of which were emphasized at the annual conference in March, 1921. Other activities of the Council during the year and reports of progress are as follows:

HOSPITAL STATISTICS

Tabulated statistics showing the supply of hospitals in the United States were given in the first "Hospital Number" of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, that of April 16, 1921. These statistics provide information of special value at this time, since from the data published it is easy to ascertain whether or not any particular community is adequately provided with hospital facilities. Table 1 shows the number of counties in each state which are entirely without hospitals and it is interesting to note that in the entire United States 56 per cent. of all counties are without hospitals.

Colorado	63	20	9
Connecticut	8	8	0
Delaware	3	1	0
Dist. of Columbia	1	1	0
Florida	54	13	0
Georgia	152	21	7
Idaho	41	11	4
Illinois	102	51	10
Indiana	92	37	16
Iowa	99	37	19
Kansas	105	33	12
Kentucky	120	21	11
Louisiana	64	10	6
Maine	16	12	2
Maryland	24	12	1
Massachusetts	14	12	1
Michigan	83	30	18
Minnesota	86	40	23
Mississippi	82	17	5
Missouri	115	20	6
Montana	44	21	7
Nebraska	93	19	16
Nevada	16	7	6
New Hampshire	10	10	0
New Jersey	21	17	2
New Mexico	28	11	4
New York	61	48	5
North Carolina	100	31	9
North Dakota	53	13	11
Ohio	88	46	9
Oklahoma	77	18	9
Oregon	36	17	6
Pennsylvania	67	52	2
Rhode Island	5	3	0
South Carolina	45	17	1
South Dakota	69	15	6
Tennessee	96	14	8
Texas	251	43	21
Utah	29	6	3
Vermont	14	7	3
Virginia	100	23	6
Washington	39	20	4
West Virginia	55	23	4
Wisconsin	71	33	12
Wyoming	21	6	8
Totals			

ernment hospitals, which are limited to the care of soldiers, sailors, marines and other government employees, and state institutions, asylums and other institutions providing largely for the custodial care of severe cases of tuberculosis, and of insane and other incurable cases, are not included in the calculation, but are dealt with separately.

In collecting these data for publication, unusual efforts were made to obtain information by which all institutions having more than 25 beds could be named in the list, and that all others having between 10 and 25 beds could be included in the calculations. The publication of the report has already had good results, in that several other hospitals, the existence of which was entirely unknown, have since sent in reports, and still others have reported enlargements of their bed capacity, so that our list and data are now more complete.

HOSPITALS PROVIDING GENERAL CARE FOR THE PUBLIC

There are 4,013 private, general or special hospitals open to the public for the general care of the sick. Of these, 2,926 have twenty-five or more beds, while 1,087 have less than twenty-five beds each. Of the 2,926 hospitals having twenty-five or more beds, 483 have been approved for the training of interns. Those marked with an asterisk (*) are general hospitals, while those marked with a dagger (†) are approved for interns who wish to secure clinical training in the specialty which the hospital emphasizes. The fact that a hospital is not approved for the training of interns should not be misinterpreted to mean that the hospital is not providing satisfactory care for its patients. On the contrary, there are many hospitals rendering a very excellent service to their patients which do not seek or utilize interns, and which are undoubtedly worthy of approval as non-intern hospitals.

FACTORS INDICATING NEED AND PRESENT SUPPLY OF HOSPITALS

There are four factors to be considered in determining whether or not any given district, state or community has an adequate supply of hospitals. These are (*a*) the ratio of square miles of area to each hospital; (*b*) the ratio of hospital beds to population; (*c*) the percentage of beds on the average which are in constant use, and (*d*) the percentage of counties which have no hospitals. There are at present 4,013 of these

hospitals in the United States with a total of 311,159 beds—one bed to every 340 persons—and of these beds 206,024, or 67 per cent., are in use. There is one hospital on the average to every 741 square miles, ranging from one to every forty-two square miles in Massachusetts to one to every 5,780 square miles in Nevada. The situation in Nevada appears to be less serious, however, than in Mississippi, where there is one hospital to every 1,104 square miles. The latter state is more thickly populated and has only one hospital bed to every 1,054 persons, while Nevada has one bed to every 139. Of the 3,027 counties in all states, 1,695, or 56 per cent., have no hospitals. Table 2 shows the supply of all states arranged by districts. The North Atlantic district is fairly well supplied with hospitals as compared with the South Central and

TABLE 2.—HOSPITALS SHOWN BY STATES IN DISTRICT GROUPS

State	Area, Square Miles	Square Miles per Hospital	Ratio of Beds to Population	Percentage of Beds Occupied	Percentage of Counties With No Hospitals
North Atlantic States					
Maine	29 895	695	389	60	12.5
New Hampshire	9,031	291	328	60	0.0
Vermont	9,124	415	470	69	28.6
Massachusetts	8,039	42	254	63	7.2
Rhode Island	1,067	56	288	75	40.0
Connecticut	4,820	100	312	73	0.0
New York	47,654	128	185	68	13.1
New Jersey	7,514	77	320	59	9.5
Pennsylvania	44,832	165	286	69	20.9
Totals	161,976	148	242	67	15.3
South Atlantic States					
Delaware	1,965	281	444	66	66.7
Maryland	9,941	203	231	71	45.8
Dist. of Col.	60	3	165	73	0.0
Virginia	40,262	559	484	67	71.0
West Virginia	24,022	429	400	50	50.9
North Carolina	48,740	625	761	63	60.0
South Carolina	30,495	782	881	63	60.0
Georgia	58,725	1,032	897	65	81.6
Florida	54,861	1,483	583	58	76.0
Totals	269,071	650	508	65	68.4

North Central States					
Ohio	40,740	229	388	66	37.5
Indiana	36,045	337	500	66	42.4
Illinois	56,043	228	282	66	41.2
Michigan	57,480	414	398	69	42.2
Wisconsin	55,256	428	348	66	36.6
Minnesota	80,858	484	236	65	26.7
Iowa	55,586	456	377	65	43.4
Missouri	68,727	739	431	64	77.4
North Dakota	70,183	1,755	393	64	54.7
South Dakota	76,868	2,261	321	61	69.6
Nebraska	76,808	1,113	369	66	62.4
Kansas	81,774	919	465	62	57.1
Totals	756,368	536	355	66	62.0
South Central States					
Kentucky	40,181	638	653	64	73.3
Tennessee	41,687	744	679.	66	77.1
Alabama	51,279	1,047	767	49	74.6
Mississippi	46,362	1,104	1,054	66	73.2
Louisiana	45,409	1,195	507	74	75.0
Texas	262,396	1,874	617	58	50.6
Arkansas	52,525	2,529	857	48	76.0
Oklahoma	69,414	1,262	980	58	65.0
Totals	609,255	1,248	705	61	73.8
Western States					
Montana	146,201	3,178	220	59	36.4
Wyoming	97,594	4,436	278	72	33.3
Colorado	103,658	1,481	198	72	53.9
New Mexico	122,503	3,403	237	66	46.4
Arizona	113,810	2,529	196	59	14.3
Utah	82,184	5,479	430	63	69.0
Nevada	109,821	5,780	139	48	18.7
Idaho	83,354	2,977	430	54	63.4
Washington	66,836	786	243	66	38.4
Oregon	95,607	2,078	318	67	36.1
California	155,652	741	210	76	20.7
Totals	1,177,220	1,893	211	69	41.4
All states	2,973,890	741	340	67	56.0

the Western Districts. But a study of the figures shows that in the North Atlantic, as well as in other districts, owing to a poor distribution, some portions have an abundance of hospitals while other sections are entirely lacking.

HOSPITALS UNEQUALLY DISTRIBUTED

As to the adequate proportion of hospital beds to population, estimates by experts vary in stating that there should be one bed to every 300 to 500 persons. These statistics show one bed to every 340 persons, which would indicate an adequate supply, but since 56 per cent. of all counties are without hospitals, it is evident that the supply is poorly distributed. With a better distribution, it is quite probable that the proportion of beds in use would be much larger than 67 per cent., as shown in the statistics. An investigation of the supply in Delaware shows that the seven hospitals in that state are all located in the extreme north end—a part where the public has also the easiest access by rail to the hospitals of Baltimore and Philadelphia—while four fifths of the state have no hospitals. [Charts showing the hospital supply for all states have been prepared and are shown in the Scientific Exhibit.]

The lesson to be learned from the figures published in the Hospital Number of THE JOURNAL is that in the establishing of hospitals hereafter, communities should be selected which are not already abundantly or overabundantly supplied. From these statistics it can be ascertained which communities are in greater need of hospitals.

MEDICAL COLLEGES

As shown in previous reports, the Council's work with medical colleges has aided largely in reducing an abnormal over-supply to a number which is still more than adequate to meet the requirements of the country. Instead of there being 162 medical schools, which was the case in 1906, there are now 84 institutions. This reduction was brought about largely through the merger of two or more schools existing in each of several cities and in the closing of others, most of which were of low grade. As to entrance requirements, however, instead of there being only four institutions requiring for admission any college work, now seventy-six of the eighty-four require two or more years of collegiate work in addition to a high school education. This increase in entrance requirements, meanwhile, is merely an index of the improvements which have taken place in other respects. The educational standards of medical colleges in the United States are now on a par with, or in excess of, those in other leading nations. This country also has an increasing number of medical schools which, from the standpoint of teachers, laboratories,

equipment and clinical facilities, are fully equal to the best medical schools abroad. Reports indicate that three other medical schools will not reopen next fall which will further reduce the number of medical colleges to eighty-one.

MEDICAL STUDENTS

Under the low education standards which were so general among medical schools in 1904 under the special efforts and inducements to increase the enrolments, and the sharp competition between various schools for students, it was not surprising that the total registration in medical schools in that year reached the maximum and 28,142 students were enrolled. Here, as in the case with medical colleges, the supply was abnormally large. With the rapidly increasing entrance requirements and the marked reduction in the number of medical schools it was expected that the number of students would be greatly reduced. The enrolment reached its lowest ebb in 1919 when 13,052 students were enrolled. The enrolment for 1920 was 14,088 and, on the basis of reports received from all but five colleges, the enrolment for 1920-1921 is approximately 14,850.

TABLE 3.—LOWEST EBB IN ENROLMENTS OF MEDICAL STUDENTS

	1st Year	2d Year	3d Year	4th Year	5th Year	Total
1913-14	4,684	3,981	3,807	3,955	...	16,502
1914-15	3,373	3,919	3,675	3,864	...	14,891
1915-16	3,582	3,094	3,559	3,727	...	14,022
1916-17	4,107	3,117	2,866	3,674	...	13,764
1917-18	4,283	3,521	2,893	2,933	...	13,630
1918-19	3,104	3,587	3,272	2,967	122	13,052
1919-20	3,234	2,837	3,464	3,262	290	14,088
1920-21	4,860	3,584	2,644	3,370	392	14,850

As shown in Table 3 the lowest ebb in the numbers of medical students, which can be calculated as due to the increased requirements for admission to medical schools, began with the first-year class in 1914-1915, ending with the lowest total enrolment in the session of 1918-1919. This low ebb is indicated by the heavy line under the totals in the various classes between those two dates. A still lower ebb

in the individual classes indicated by the light line underscoring, began with the freshman class in the session of 1918-1919. This was due clearly to the volunteering or drafting of medical students during the war. This reduction, however, was not sufficient to affect the total enrolment which shows a continued increase since 1918-1919.

AGE OF STUDENTS ENTERING MEDICAL SCHOOLS IN 1920

Reports obtained from the first year medical students enrolled in seventy-six of the eighty-four colleges in the fall of 1920 totaled 4,532, and of these 1,076, or 24 per cent., were between the ages of 17 and 20; 2,130, or 47 per cent., were between the ages of 21 and 23; 1,013, or 22 per cent., were between the ages of 24 and 27, and 313, or 7 per cent., were 28 years of age or over. Three thousand two hundred and six, or 71 per cent., therefore, were under 24 years of age. This indicates that four years later on completing their medical course, 3,206 students will be from 24 to 27 years of age, while 1,326 or 29 per cent., will be 28 years of age or over. In this connection it is interesting to know that of these 4,532 students 2,472, or 55 per cent., presented in addition to a four-year high school education two years of premedical college work; 1,059, or 23 per cent., presented three years of college work, and 1,002, or 22 per cent., presented four years of college work or had obtained degrees. Every one of the 4,532 reported had two or more years of premedical college work.

TABLE 4.—AGES OF FIRST YEAR STUDENTS ENTERING MEDICAL COLLEGES IN THE SESSION OF 1920-21

Ages on Entering	Number of Students	Percentage of All 1st Year Students	Minimum Age at Graduation
17 to 20	1,076	24	21 to 24
21 to 23	2,130	47	25 to 27
24 to 27	1,013	22	28 to 31
28 and over	313	7	32 and over
Total.....	4,532	100	

MEDICAL GRADUATES

Under the low requirements and general conditions prevailing among medical schools in 1904 the number of graduates in that year reached the maximum when 5,747 medical students were graduated. Here, again, under the higher entrance requirements and the reduced number of medical

schools, a rapid reduction took place until in 1919 the lowest ebb was reached and in that year 2,656 were graduated. The total number of graduates in 1920 was increased to 3,047 and an estimate for the year 1920-1921 indicates that approximately 3,350 medical students will receive their degrees. It is interesting to know, however, that the percentage of graduates from Class A medical schools[1] has increased from 64 per cent. in 1913 to 88 per cent. in 1920; that the percentage of graduates from Class B colleges has decreased from 24 per cent. in 1913 to 5 per cent. in 1920, and from Class C colleges the reduction has been from 26 per cent. in 1913 to 5 per cent. in 1920. Seven Class C medical colleges still exist, of which three are in Missouri, two in Massachusetts and one each in Illinois and Tennessee.

MEDICAL LICENSURE

During the last four years in the State Board Number of THE JOURNAL, the Council has included a table (See Table 5) showing for each state the numbers of physicians registered who graduated from medical schools rated, respectively, in Classes A, B and C. This table deserves careful study by the members of the House of Delegates, so that the attention of each state medical association may be called to the conditions found. Six states stand out prominently as having registered large numbers of graduates from Class C medical schools or as having granted physicians' licenses to osteopaths. These are Arkansas, California, Colorado, Illinois, Massachusetts and Texas. In Arkansas, the fault is with the medical practice act which has divided the authority for the licensing of physicians between three separate boards and the graduates of Class C colleges were all registered by the Board of Eclectic Medical Examiners. The numbers in California, Colorado and Texas are increased considerably by the granting of physicians' licenses to osteopaths regardless of their lower educational and professional qualifications. In Illinois and Massachusetts the numbers are due to the presence in those states of Class C medical schools which are still recognized by the licensing boards of those states. In Massachusetts, however, the board has no option in the matter, in spite of repeated attempts which have been made to secure that authority. In Missouri, unfortunately, an amendment to the practice act was passed this spring and signed by the Governor, in spite of most vigorous protests on the

1. See THE JOURNAL A. M. A., Aug. 7, 1920, Table 12, p. 387.

part of the medical profession, the universities and many prominent citizens of that state, which takes away from the licensing board the authority to refuse recognition to the three Class C medical schools in that state. Meanwhile, the number of states in which the licensing boards are refusing recognition to low type medical colleges has increased since 1914 from thirty-two to forty-four states. In Table 5, candidates who graduated prior to 1907 are classed as miscellaneous since medical schools were not rated by the Council until 1907. Graduates of foreign medical schools are also included among miscellaneous excepting those of Canadian colleges which are included in the Council's classification.

It is encouraging to note (see Table 6) that during the last four years both the number and percentage of Class A graduates who have been registered have considerably increased while for the Class B and Class C graduates the numbers and percentages have decidedly decreased. The percentage of miscellaneous graduates remains about the same for the last three years.

TABLE 6.—SOURCE OF PHYSICIANS LICENSED IN THREE YEARS

Year	Medical Colleges in						Miscellaneous and Foreign Colleges		Total
	Class A		Class B		Class C				
	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	Number	Per Cent.	
1917	3,369	62.1	988	18.2	297	5.3	769	14.4	5,423
1918	2,456	58.7	682	16.3	342	8.2	705	16.8	4,185
1919	4,368	66.4	872	13.2	278	4.2	1,066	16.2	6,584
1920	4,597	70.2	631	9.6	275	4.2	1,054	16.0	6,557
Totals	14,790	65.0	3,173	14.0	1,192	5.2	3,594	15.8	22,749

MEASURES NEEDED TO INSURE PERMANENCY

The success in bringing about the reorganization of medical education has been due largely to the united action of all agencies interested in developing medical education through the Council's Annual Conferences on Medical Education and Licensure but more particularly to the splendid cooperation and aid which the Council has received from officers of medical schools and the secretaries of state licensing boards. Along with the improvements in medical edu-

cation there has been a gradual improvement in the educational standards of state licensing boards and a better enforcement of medical practice laws.

The extensive improvements in medical colleges since 1904 have encouraged the hope that after a few more years the entire output from medical colleges will be limited to physicians thoroughly qualified as regards both preliminary and professional education. An increasing number of licensing boards have refused recognition to extremely low-grade medical colleges and all but a few which are strongly entrenched politically have been exterminated.

MENACE OF MEDICAL CULTS

In recent years, however, the progress in medical licensure has been menaced by the efforts of certain cults, the more aggressive of which have been the osteopaths and chiropractors. Under the claim that since they "did not use drugs or perform surgical operations" they "were not practicing medicine," these healers have succeeded in securing legislation in a number of states providing for separate boards of examiners, or special clauses in the medical laws, permitting them to practice and exempting them from the educational qualifications which physicians are required to possess. Through their central organizations also these cults are carrying on a systematic and persistent campaign of advertising in order to create public sentiment in their favor. The medical profession is the only organization which is in position to expose the fallacies of their claims and point out their lack of the essential knowledge and training required for any intelligent care of the sick. This is why much of their advertising is devoted to efforts to discredit the medical profession. The only logical and effective argument against them is not to the osteopaths and chiropractors as such, but to their lack of adequate educational qualifications—to their lack of training in the modern methods of diagnosis, treatment and prevention of diseases. Such good as there may be in the character of treatment they employ will in no way be reduced if those using such methods are first required to possess the educational qualifications which will make them safe practitioners of the healing art.

The chief danger from these cults at present—and which is the chief reason for referring to them—is through their efforts to break down medical practice laws and the confusion that they are causing in medical licensure. As might be expected, the osteopaths, after having secured authority to practice

under limited licenses, are now demanding all the privileges which physicians enjoy. Although licensed under the claim that they "did not use drugs," they later have sought registration under the Harrison Law for permission to use narcotics—the most dangerous of drugs. During the recent session of the various legislatures they have been demanding the right to perform surgical operations and exercise all other functions now exercised only by qualified physicians, including the right to sign death certificates. These demands cannot logically be objected to if at the same time they are willing to show that they possess the same educational qualifications as are required of physicians. But this is not the case; they are still insisting on lower standards of both preliminary and professional training.

Logically, no one should be authorized to treat the sick by any method unless he has had a thorough training in the fundamental medical sciences. No one should be granted "limited licenses." When a patient in an emergency calls a "doctor" he needs one who is competent to use whatever remedies or method of treatment the particular ailment requires. These essentials are not provided in a practitioner who is neither qualified nor legally authorized to practice medicine in all its branches. The legal error was made when these cultists were authorized by legislation to practice under limited licenses. We know of no parallel to this in the medical practice laws of any other country.

CORRECTIVE LEGISLATION ESSENTIAL

During the last year, however, there have been evidences of a clearer vision on the part of our legislators, and the laws enacted in several states have been favorable to medical education. Efforts to secure separate boards in several states were defeated, while in New Jersey a law was passed abolishing a chiropractic board which had been illogically established by the action of the previous legislature. A similar corrective law should be passed in each of several states abolishing all special boards created by previous legislatures. In each state there should be established one educational standard, administered by a single licensing board by which everyone who is authorized to practice the healing art shall be required to prove that he has secured a satisfactory training in the fundamentals of medicine. Osteopathic and chiropractic colleges, furthermore, should be inspected and classified in accordance with the same standards of measurement now being applied in medical schools and by the same boards

who pass on medical schools. In Indiana, the same standards of preliminary and professional education are applied by the Board of Medical Examiners to osteopaths and chiropractors as are applied to physicians. In some states the osteopaths are required to take the same comparatively easy examination that is required of physicians but they are not required to have the same preliminary qualifications which all physicians are now required to possess. What the medical profession has a right to demand is a square deal and equal qualifications for all and that there shall be no discrimination favoring any individual or group of individuals who are engaged in the healing art. It is desirable that all legislation affecting the practice of medicine in future shall support the present reasonably high standards of medical education, for which, in the last fifteen years, the various agencies interested in medical education have successfully struggled.

SUMMARY

1. One of the most effective methods of work carried on by the Council on Medical Education and Hospitals has been the annual conference on medical education which resulted in bringing about a unanimity of action between the various agencies working for the improvement of medical education.

2. The work of the Council has expanded to cover preliminary education, the undergraduate medical curriculum, hospitals in their relation to clinical teaching and the intern year, graduate medical education, and graduate courses for the training of specialists. Last year, through the action of the House of Delegates, the Council's function in relation to hospitals was broadened to include the general survey of all hospitals.

3. The reorganization of medical education, which was the original object for which the Council on Medical Education was created, has been practically completed. With the broadening of the Council's function, however, there still remains much to do.

4. There is but one science of medicine, which cannot be subdivided into specialties or limited to the eye, the heart, the stomach or other region; it covers the entire human body in health and in disease.

5. A careful study of the present situation shows an excessive trend towards specialism which is largely due to the present faulty undergraduate curriculum. Furthermore, many are assuming the function of specialists who have not obtained adequate training in their chosen specialty.

6. The undergraduate medical curriculum should be reorganized so as to give the graduate a more thorough grounding as a general practitioner of medicine and less emphasis should be given to certain specialties.

7. Medical students should have their attention especially called to the unusual opportunities for study and research and the other advantages of general practice, as well as to the increased importance of the general practice of medicine.

8. It is in the practice, or art of medicine where specialization properly comes and training in each specialty comes properly in graduate courses. Minimum suggestive standards of instruction in the various specialties were presented in a series of reports at the Council's conference in March, 1921.

9. There are dangers in specialism unless (*a*) the specialist has had a broad training and experience in general medicine as a foundation, or (*b*) unless patients sent to specialists are first carefully examined by a broadly trained general practitioner, who in a general way controls the diagnosis and therapy in the case.

10. The hospital statistics published in the recent Hospital Number of THE JOURNAL show that 56 per cent. of all counties in the United States do not have hospitals. Indications are that the chief trouble in connection with the hospital supply in the United States is inadequate distribution.

11. The enrolment of medical students reached its lowest ebb in 1919, when 13,052 students were enrolled. In 1920, there were 14,088 and, based on reports received from most colleges, the present enrolment is approximately 14,850.

12. A study of the records of freshman students in the fall of 1920 shows that on entering the medical school, 1,076, or 24 per cent., were between the ages of 17 and 20; 2,130, or 47 per cent., were between the ages of 21 and 23; 1,013, or 22 per cent., were between the ages of 24 and 27, and 313, or 7 per cent., were 28 years of age or over. It is noteworthy that 3,206, or 71 per cent., were under 24 years of age, which will make them under 28 years of age on completing their medical course.

13. Statistics of medical licensure show that five states are registering unusually large numbers of graduates of low-grade medical colleges or granting physicians' licenses to osteopaths.

14. During the last four years, the percentage of Class A graduates who were licensed increased from 62 to 70 per cent., while of Class B graduates the number decreased from 18 to 10 per cent., and of Class C graduates the number

decreased from 5 to 4 per cent. Approximately 16 per cent. of those licensed each year graduated before medical colleges were classified by the Council or graduated from foreign medical schools.

15. There is special need that the medical profession develop some method by which the great possibilities of modern medicine, in the way of diagnosis, treatment and prevention of diseases, may be brought within the reach of all people. This function, it is believed, should be performed by the medical profession and not through any form of state medicine.

16. In several states laws have been enacted creating two or more separate boards having to do with the licensing of those who are to treat the sick. This is an illogical arrangement. It is urged that in each of these states corrective legislation be enacted—as was done this year in New Jersey whereby a single board of competent examiners may be substituted for the two or more now existing. It is further urged that the law also provide a standard of preliminary and professional training for all practitioners which will uphold the standard of medical education for which the various agencies interested in medical education have successfully struggled during the last fifteen years.

Respectfully submitted,

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS.

ARTHUR DEAN BEVAN, Chairman, MERRITTE W. IRELAND,
WILLIAM D. HAGGARD, RAY LYMAN WILBUR,
WILLIAM PEPPER, N. P. COLWELL, Secretary.

Report of the Council on Scientific Assembly

To the Members of the House of Delegates of the American Medical Association:

On December 10, the Council held a conference with the secretaries of the several sections at the headquarters of the Association. All the sections were represented either by their secretaries or by one of the other executive officers. All the members of the Council were present with the exception of Dr. Roger S. Morris and the President-Elect who were detained by urgent personal business.

The assignment for meeting hours of the different sections for the 1921 annual session was announced as follows:

Sections to convene at 9 o'clock in the morning of Wednesday, Thursday and Friday, June 8, 9 and 10: Practice of Medicine; Obstetrics, Gynecology and Abdominal Surgery; Laryngology, Otology and Rhinology; Pathology and Physiology; Stomatology; Nervous and Mental Diseases; Urology; and Preventive Medicine and Public Health.

Surgery, General and Abdominal; Ophthalmology; Diseases of Children; Pharmacology and Therapeutics; Dermatology and Syphilology; Orthopedic Surgery; Gastro-Enterology and Proctology; and a meeting of the Section on Miscellaneous Topics to present a program on anesthesia.

The members of the Executive Committee of the Board of Trustees were also in attendance at the conference and plans were formulated so that, with the cooperation of the officers of the sections, it is hoped the scientific Exhibit will be made of greater interest and value to those who attend the annual sessions. These plans include the arranging of the Scientific Exhibit in three general divisions: One presenting subjects falling within the scope of pathology and physiology; another, medical topics; and the third, surgical subjects. With the carrying out of these plans for the Scientific Exhibit, it is hoped that much time in section meetings now occupied with demonstrations can be utilized in discussions, and that the demonstrations can be presented more effectively at stated hours in the Scientific Exhibit, so conserving the time of the section meetings and enhancing the educational value of the Scientific Exhibit. It was the general consensus of opinion of all in attendance at the conference that a closer coopera-

tion between the sections and the Scientific Exhibit is possible and advisable, and the officers of the sections expressed their willingness to assist in assembling and presenting material in the Scientific Exhibit. While it may not be possible to carry out this close cooperation between the sections and the Scientific Assembly at the 1921 annual session, an effort is being made to begin this work at the Boston Session with the hope that the plans may be improved from year to year until the exhibit and the section programs shall fully complement, one the other.

The Council on Scientific Assembly has been advised that a number of members of the organization and Fellows of the Scientific Assembly desire the House of Delegates to create a Section on Anesthesia. Communications have been transmitted also to the Council through the office of the Secretary of the Association suggesting that sections shall be established on History of Medicine, on Legal Medicine, on Anatomy and on Industrial Medicine. The only formal petition, however, requesting the establishment of a new section is for a Section on Anesthesia. The Council has given careful consideration to this petition and is unanimous in its opinion that no new sections should be created until after it is demonstrated that there is an actual demand for a new division of the Scientific Assembly.

The Council proposes to use the meetings falling within the Section on Miscellaneous Topics for the presentation of programs which are desired by considerable numbers of Fellows. It will be noted that the Council has arranged that one meeting of the Section on Miscellaneous Topics this year shall be devoted to a program on anesthesia.

It is recommended to the House of Delegates that no new section shall be created this year. The By-Laws make it possible for the Council on Scientific Assembly to use the meetings of the Section on Miscellaneous Topics for programs presenting one or more of the subjects for which sections are asked. These or similar topics can be discussed from year to year without the establishment of a separate section and without unduly complicating the present arrangement of the Scientific Assembly. Any considerable group of Fellows who wish to develop a proposed section may utilize the Section on Miscellaneous Topics for several years and if a real need for a new section appears, it may then be created. In other words, the Section on Miscellaneous Topics may serve as an experimental laboratory to try out over a period of years the desirability of establishing a new section. Adding another

section to the Scientific Assembly involves a very grave responsibility and one which should not be lightly undertaken.

Our present plan has the advantage of continuity of section work in the programs of succeeding years. This has been gradually developed to the advantage of our scientific work during the past decade through the practice, which the sections have established, of electing the secretary for a term of at least three years. The Council feels that it would be a mistake to make any radical changes in the method of conducting our Scientific Assembly, but if additional sections are to be created, it seems evident that some arrangement must be made so that a responsible council or body will have entire charge of the Scientific Assembly and authority to modify the grouping of papers in different sections for each year's program.

Respectively submitted,

J. SHELTON HORSLEY, Chairman.
E. S. JUDD.
ROGER S. MORRIS.
F. P. GENGENBACH.
JOHN E. LANE,

Ex-officio.

HUBERT WORK, President-Elect.
GEORGE H. SIMMONS,
Editor and General Manager.
ALEXANDER R. CRAIG, Secretary.

Constitution and By-Laws

OF THE

American Medical Association

REVISION OF 1920
AND
STANDING RULES

Constitution and By-Laws of the American Medical Association

1920

Constitution

Article 1.—Title and Definition

The name of this corporation is the American Medical Association; it is a federacy* of its constituent associations.

Article 2.—Objects

The objects of the Association are to promote the science and art of medicine and the betterment of public health.

Article 3.—Constituent Associations

Constituent associations are those state and territorial medical associations which are, or which may hereafter be, federated to form the American Medical Association, in accordance with this Constitution and By-Laws.

[**Federacy: A federation or union of several states under one central authority, consisting of delegates from each state in matters of general polity but self-governing in local matters. American Dictionary and Cyclopedia.*]

ARTICLE 4.—COMPONENT SOCIETIES

Component societies are those county or district medical societies contained within the territory of and chartered by the respective constituent associations.

ARTICLE 5.—HOUSE OF DELEGATES

SECTION 1.—The legislative powers of the association reside in the House of Delegates. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws, and shall elect the general officers.

SEC. 2.—COMPOSITION.—The House of Delegates is composed of delegates elected by the constituent associations and by the Sections of the Scientific Assembly, and of delegates from the Medical Departments of the Army and the Navy and the Public Health Service, appointed by the Surgeon-General of the respective departments. The Trustees shall be ex-officio members of the House of Delegates, but without the right to vote.

SEC. 3.—The total voting membership of the House of Delegates shall not exceed 150. The medical departments of the Army and of the Navy, and the United States Public Health Service and the scientific sections shall each be entitled to one delegate, and the remainder shall be apportioned among the Constituent Associations in proportion to their actual active membership as hereinafter provided in the By-Laws.

ARTICLE 6.—GENERAL OFFICERS

SECTION 1.—The general officers of the Association shall be a President, a Vice President, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House of Delegates, and nine Trustees.

SEC. 2.—These officers shall be elected annually and shall serve for one year, except the Trustees, three of whom shall be elected annually, each to serve three years, or until their successors are elected and installed.

ARTICLE 7.—TRUSTEES

The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations.

ARTICLE 8.—MEMBERS AND FELLOWS

SECTION 1.—MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION.—Members in good standing of the constituent associations are the members of the American Medical Association, subject, however, to the provisions of these By-Laws regarding members.

SEC. 2.—FELLOWS OF THE SCIENTIFIC ASSEMBLY.—Members in good standing of the Association who have complied with the provisions of the By-Laws regarding Fellows, are Fellows of the Scientific Assembly of the American Medical Association.

ARTICLE 9.—SCIENTIFIC ASSEMBLY

SECTION 1.—The Scientific Assembly of the American Medical Association is the convocation of its Fellows for the presentation and discussion of subjects pertaining to the science and art of medicine.

SEC. 2.—The Scientific Assembly is divided into sections, each section representing that branch of medicine described in its title.

SEC. 3.—New sections may be created or existing sections discontinued by the House of Delegates. The Scientific Assembly and its sections shall be conducted in accordance with the rules and regulations set forth in this Constitution and By-Laws.

ARTICLE 10.—ANNUAL SESSIONS

The House of Delegates and the Scientific Assembly shall meet annually at times and places to be fixed by the House of Delegates. The time and place of any of these sessions may, however, be changed by the unanimous action of the Board of Trustees at any time prior to two months of the time selected for that session. A session may be held at any place in the United States.

ARTICLE 11.—FUNDS

Funds may be raised by an equal assessment of not more than ten dollars annually on each of the members; from the Association's publications, and in any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to defray the expenses of the Association; to carry on its publications; to encourage scientific investigations and for any other purpose approved by the Board of Trustees.

ARTICLE 12.—AMENDMENTS

The House of Delegates may amend this Constitution at any annual session, provided the proposed amendment shall have been introduced at the pre-

ceding annual session, and provided three fourths of the voting members of the House of Delegates registered at the session at which action is taken vote in favor of such change or amendment.

By-Laws

BUSINESS AND LEGISLATION

Chapter I.—Qualifications, Term, Apportionment and Registration of Delegates

Section 1. Delegates Must Have Been Fellows of the American Medical Association Two Years.—A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.

Sec. 2. Term.—Delegates and alternates from constituent associations shall be elected for two years. Constituent associations entitled to more than one representative shall elect them so that one-half, as near as may be, shall be elected each year. Delegates and alternates elected by the sections, or delegates appointed from the United States Army, United States Navy and United States Public Health Service shall hold office for one year.

Sec. 3. Apportionment of Delegates.—At the annual session of 1903, and every third year thereafter, the House of Delegates shall appoint a committee of five on reapportionment, of which the Speaker and the Secretary shall be members. The committee shall apportion the delegates among the constituent associations in accordance with Article 5, Section 3 of the Constitution, and in proportion to the membership of each constituent association as recorded in the office of the Secretary of the American Medical Association on April 1 of the year

in which the apportionment is made. This apportionment shall take effect at the next succeeding annual session, and shall prevail until the next triennial apportionment, whether the membership of the constituent association shall increase or decrease.

SEC. 4. REGISTRATION OF DELEGATES.—Each delegate representing a constituent association, before being seated, shall deposit with the committee on credentials a certificate signed by the Secretary and under the seal of the constituent association stating that he has been regularly elected a delegate by that constituent association. Each delegate from a section shall present similar credentials signed by the chairman and the secretary of the section which he represents. Each delegate from a government service shall present credentials stating he has been duly appointed by the Surgeon-General of the department which he represents.

SEC. 5. A DELEGATE, ONCE SEATED, TO RETAIN HIS SEAT FOR THE ENTIRE SESSION.—A delegate whose credentials have been accepted by the committee on credentials and whose name has been placed on the roll of the House, shall remain a delegate of the body which he represents until final adjournment of the session, and his place shall not be taken by any other delegate or alternate.

CHAPTER II.—PROCEDURE OF HOUSE OF DELEGATES

SECTION 1. ORDER OF BUSINESS. — The following shall be the order of business, unless otherwise ordered:

1. Call to order by the Speaker.
2. Roll call.

3. Reading and adopting the minutes.
4. Reports of officers.
5. Reports of committees.
6. Unfinished business.
7. New business.

SEC. 2. LIMIT OF TIME FOR INTRODUCTION OF NEW BUSINESS.—Unanimous consent shall be required for the introduction of new business at the last meeting of the annual session of the House of Delegates, except when presented by the Board of Trustees, the officers of the sections, or the sections. All new business so presented shall require three-fourths affirmative vote for adoption.

SEC. 3. RULES OF ORDER.—The House of Delegates shall be governed by Robert's Rules of Order when not in conflict with these By-Laws or with the rules of the House.

SEC. 4.—QUORUM.—Twenty voting members of the House of Delegates shall constitute a quorum.

CHAPTER III.—MEETINGS OF THE HOUSE OF DELEGATES

SECTION 1. REGULAR SESSIONS.—The House of Delegates shall meet annually on the Monday preceding the opening of, and at the same place as, the Scientific Assembly of the Association.

SEC. 2.—SPECIAL SESSIONS.—Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty-seven or more delegates, representing a majority of the constituent associations. When a special session is thus called, the Secretary shall mail a notice to the last known address of each member of the last House of Delegates at least twenty days before such special session

is to be held, in which notice shall be specified the time and place of meeting and the items of business to be considered. No other business shall be transacted at the special session than that specified in the call.

CHAPTER IV.—NOMINATION AND ELECTION OF OFFICERS, ASSOCIATE AND HONORARY FELLOWS, INSTALLATION OF OFFICERS

SECTION 1. NOMINATIONS.—Nominations for office shall be made orally, but a nominating speech must not exceed two minutes. The Treasurer shall be nominated by the Board of Trustees. No member of the House of Delegates nor general officer of the Association shall be eligible to the office of President or Vice President.

SEC. 2. QUALIFICATIONS OF GENERAL OFFICERS.—The General Officers must have been members of the Association and Fellows of the Scientific Assembly for at least two years next preceding their election. The Speaker and Vice Speaker of the House may but need not be elected from among the members of the House.

SEC. 3. METHOD OF HOLDING ELECTIONS.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. However, when there is only one nominee for an office, a majority vote without ballot shall elect.

SEC. 4. TIME OF ELECTION.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the afternoon of the fourth day of the Annual Session of the House of Delegates (Thursday), provided, however, that the House of Delegates may change the time of election by action taken at least one day in advance of that to which the election is to be changed, and provided further that the motion to change the time of election shall be supported by two-thirds of the delegates registered.

The election of Affiliate, Associate and Honorary Fellows shall immediately follow the election of officers. Not more than three Honorary Fellows shall be elected at any annual session except on special recommendation of the Council on Scientific Assembly and the unanimous vote of the House.

SEC. 5. ASSOCIATE FELLOWS. — Applications for Associate Fellowship from foreign physicians must be approved by the Judicial Council; applications from dentists must be approved by the Section on Stomatology, from pharmacists by the Section on Pharmacology and Therapeutics, and from representative teachers and students of science allied to medicine by the officers of a section.

SEC. 6. AFFILIATE AND HONORARY FELLOWS.—Nominations for Affiliate Fellowship shall be made by the constituent association of which the nominee is a member, and nominations for Honorary Fellowship shall be made by the sections, and must be submitted to the House of Delegates not later than the second day of the Scientific Assembly.

These nominations shall be referred without debate to the Council on Scientific Assembly, which shall consider the scientific attainments and professional character of the applicants and report to the House of Delegates.

SEC. 7. INSTALLATION.—The general officers of the Association, except the President, shall assume their duties at the close of the last meeting of the annual session at which they are elected.

SEC. 8. INSTALLATION OF THE PRESIDENT.—The President shall be installed at the opening general meeting of the Scientific Assembly of the annual session following that at which he was elected.

CHAPTER V.—DUTIES OF OFFICERS

SECTION 1. PRESIDENT.—The President shall preside at the general meetings of the Scientific Assembly. At the opening general meeting of the Scientific Assembly next following his election he shall deliver an address on such matters as he may deem of importance to the public and to the medical profession. He may attend the meetings of and make suggestions to the House of Delegates or the Board of Trustees. With the approval of the Board of Trustees he is authorized to appoint committees for emergencies not otherwise provided for. He shall nominate members of standing committees for election by the House of Delegates.

SEC. 2. VICE PRESIDENT.—The Vice President shall officiate for the President during the latter's absence, or at his request. In case of death, resignation or removal of the President, the Vice President shall officiate during the unexpired term.

SEC. 3. SPEAKER.—The Speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require. He shall have the right to vote only when his vote shall be the deciding vote.

SEC. 4. VICE SPEAKER.—The Vice Speaker shall officiate for the Speaker in the latter's absence or at his request. In case of death, resignation, or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.

SEC. 5. SECRETARY.—The Secretary, in addition to the duties ordinarily devolving on the secretary of a corporation and those delegated in other sections of these By-Laws, shall give due notice of the time and place of annual and special sessions of the House of Delegates and of the Scientific Assembly in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. He shall send an official notice of each annual or special session to the secretary of each constituent association and to the secretary of each section. He shall keep the minutes of the House of Delegates. He shall notify members of committees of their appointment and of the duties assigned them. He shall verify the credentials of the members of the House of Delegates and shall provide a registration book in which shall be recorded the name of each delegate in attendance at each session, together with that of the constituent association, government service or section which he represents. He shall prepare for publication the official programs for the Scientific Assembly, and shall perform such other duties as may be directed by the House of Delegates, or the Board of Trustees.

SEC. 6. TREASURER.—The Treasurer shall be the custodian of all moneys, securities and deeds belonging to the Association which may come into his possession, and shall hold the same subject to the direction and disposition of the Board of Trustees. He shall give to the Board of Trustees a suitable bond for the faithful performance of his trust, and shall receive for his service a salary to be fixed by the Board of Trustees.

SEC. 7. OFFICERS TO COMPLETE BUSINESS OF SESSION.—All business of each annual session shall be completed by the officers (including section officers) who have served during the session.

CHAPTER VI.—BOARD OF TRUSTEES

SECTION 1. BOARD OF TRUSTEES.—The Trustees at their first meeting after the annual session of the House of Delegates, shall organize by electing a chairman and a secretary, and the chairman shall appoint such committees as may be created by the Board. It shall be the duty of this Board to provide for and to superintend the publication of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and of all proceedings, transactions and memoirs of the Association. It shall have full discretionary power to omit from THE JOURNAL, in part or in whole, any paper that may be referred to it by any of the sections. It shall appoint a general manager and an editor of THE JOURNAL, which two positions may be held by one person, and such assistants as may be necessary, and shall determine their salaries and the terms and conditions of their employment. All resolutions or recommendations of the House of Delegates pertaining

to the expenditure of money must be approved by the Board of Trustees before the same shall become effective. During the annual session of the Association the Board shall hold meetings as often as may be deemed necessary by the chairman, and all matters referred to it by the House of Delegates shall be reported on within twenty-four hours, if so requested by the House. The Board of Trustees shall have the accounts of the Treasurer and of THE JOURNAL office audited annually or oftener, if deemed necessary, and shall make an annual report to the House of Delegates, which report among other items shall specify the character and cost of all the publications of the Association during the year and the amount of all property belonging to the Association. Should a vacancy occur, on account of death or otherwise, among the general officers of the Association, the Board of Trustees may fill such vacancy until the next annual session of the House, unless otherwise provided for in this Constitution and By-Laws. The Board of Trustees shall fix the salary of the Secretary and of the Treasurer. Regular meetings of the Board shall be held immediately after the annual session of the House of Delegates, and on the first Friday in the month of February of each year. Special meetings of the Board may be called at any time by the chairman, or by five members of the Board, by mailing a written or printed notice to the last known address of each trustee, at least five days before such meeting is to be held, in which notice shall be specified, in general terms, the object of such special meeting, and no other business shall be transacted thereat; provided, that the proceedings of any meeting of the

Board at which all the members are present or which are approved in writing by every member of the Board shall be valid without previous notice having been given. Five members of the Board shall constitute a quorum. During the intervals between the sessions of the House of Delegates the Board of Trustees shall supervise the action of committees constituted by the action of the House and may appoint emergency committees.

SEC. 2. TRUSTEES TO CONTROL SESSION. — The Board of Trustees shall have full control of all arrangements for the annual sessions and shall provide meeting places for the House of Delegates, the general meetings and the scientific sections. It shall also have control of all exhibits. It may appoint a local committee of arrangements, which shall be at all times under the Board.

CHAPTER VII.—COMMITTEES

SECTION 1. CLASSIFICATION OF COMMITTEES. — Committees shall be classified as (*a*) Standing Committees, (*b*) Reference Committees, and (*c*) Special Committees. The standing committees shall be nominated by the President and elected by the House of Delegates, unless otherwise provided for. Reference and special committees shall be appointed by the Speaker as provided in these By-Laws. Special committees may be created by the House of Delegates to perform the special functions for which they are created; they shall be appointed by the Speaker unless otherwise ordered by the House. Committees acting during the interval between the sessions of the House of Delegates shall be subject to the Board of Trustees. In case of vacancies in committees

occurring during the interval between annual sessions, the President or the Speaker, according to the committee on which said vacancies occur, shall have the power to appoint Fellows to fill the vacancies until the next annual session.

SEC. 2. MEMBERSHIP OF COMMITTEES.—Any Fellow shall be eligible to serve on standing or special committees. Reference committees shall be appointed from the members of the House of Delegates. Members of committees not members of the House of Delegates shall have the right to present their reports in person to the House and to participate in the debate thereon, but shall not have the right to vote. The House of Delegates may recall the election of any officer or the appointment of any member of a committee or Council at any session by a two-thirds vote of the members of the House of Delegates present and voting, provided that no motion for recall shall be acted on till the day following that on which it is introduced.

SEC. 3. STANDING COMMITTEES. — Standing committees shall be the following:

(*a*) Judicial Council.
(*b*) Council on Health and Public Instruction.
(*c*) Council on Medical Education and Hospitals.
(*d*) Council on Scientific Assembly.

CHAPTER VIII.—ORGANIZATION OF STANDING COMMITTEES OR COUNCILS

SECTION 1. MEMBERSHIP.—The Standing Committees, or Councils, shall consist of five members, each elected for five years. The term of office of the members of each committee shall terminate in succession,

one each year, and the House of Delegates shall elect annually, on nomination by the President, one member to each committee to fill the vacancy. The members of the Council on Scientific Assembly shall be chosen, as far as practical, from ex-section officers representing different sections, the President-Elect, the Secretary of the Association and the Editor of THE JOURNAL shall be ex-officio members of this Council.

SEC. 2. OFFICERS.—The Councils shall organize and elect their own officers except that the Secretary of the Association shall be the Secretary of the Judicial Council, and of the Council on Scientific Assembly and that on nomination by the respective Council, the Board of Trustees shall elect annually, to serve one year, a secretary of the Council on Health and Public Instruction and of the Council on Medical Education and Hospitals, and shall fix the salary of each.

SEC. 3. EXPENDITURES.—Each Council shall submit to the Board of Trustees a budget of its expenses for the fiscal year, and the Board shall make such appropriation for each Council as it may see fit. Each Council shall be limited in its expenditures to the appropriation made for it by the Board of Trustees and no Council shall expend or contract to expend any money in excess of its appropriation without the consent and approval in writing of the Board of Trustees.

SEC. 4. RULES AND REGULATIONS.—Each Council may make its own rules to govern its action; such rules shall not conflict with these By-Laws nor with standing rules or resolutions of the House of Delegates.

SEC. 5. COMMITTEES.—Each Council shall have authority to appoint committees subject to the approval of the Board of Trustees for any purpose within the jurisdiction of the Council.

SEC. 6. HEADQUARTERS.—The headquarters of each Council shall be at the general office of the Association where the transactions of the Council shall be recorded.

SEC. 7. REPORTS.—Each Council shall submit annually a report of its work to the House of Delegates. All such reports, so far as possible, shall be transmitted thirty days before the annual session to the Secretary of the Association, who shall have them printed for distribution to the members of the House of Delegates.

CHAPTER IX.—DUTIES OF STANDING COMMITTEES OR COUNCILS

SECTION 1. THE JUDICIAL COUNCIL.—The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final. This power shall extend to and include (1) all controversies arising under this Constitution and By-Laws to which the American Medical Association is a party; and (2) controversies (*a*) between two or more recognized constituent associations, (*b*) between a constituent association and a component society or societies of another constituent association or associations or a member or members of another constituent association or other constituent association, and (*c*) between members of different constituent associations. In all these cases the Judicial Council shall have original jurisdiction.

In all cases which arise (a) between a constituent association and one or more of its component societies; (b) between component societies of the same constituent association; (c) between a member or members and the component society to which said member or members belong, or (d) between members of different component societies of the same constituent association, the Judicial Council shall have appellate jurisdiction in questions of law and procedure but not of fact.

The Judicial Council may, at its discretion, investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary.

SEC. 2. COUNCIL ON HEALTH AND PUBLIC INSTRUCTION.—The functions of the Council on Health and Public Instruction shall embrace the following subjects: (1) Legislation. (2) Public Instruction. (3) Defense of Medical Research. (4) Public Health.

SEC. 3. COUNCIL ON MEDICAL EUCATION AND HOSPITALS.—The functions of the Council on Medical Education and Hospitals shall be: (1) To investigate conditions of Medical Education, Hospitals and associated subjects and to suggest means and methods by which the same may be improved. (2) To endeavor to further the realization of such suggestions as may be approved by the House of Delegates.

SEC. 4. COUNCIL ON SCIENTIFIC ASSEMBLY.—The function of the Council on Scientific Assembly shall be: (1) To secure cooperation between the sections.

(2) To pass upon questions of policy in relation to section work. (3) To stimulate the development of the sections. (4) To consider at first hand applications for new sections, or for changes in existing sections, and to report to the House of Delegates. (5) To appoint officers for meetings making up the section on miscellaneous topics. (6) To arrange the programs for the general meetings of the Scientific Assembly.

CHAPTER X.—REFERENCE COMMITTEES

SECTION 1. APPOINTMENT.—Immediately after the organization of the House of Delegates at each annual session the Speaker of the House of Delegates shall appoint from the members of the House such committees as may be deemed expedient by the House of Delegates. Each committee shall consist of five members, unless otherwise provided, the chairman to be specified by the Speaker. These committees shall serve during the session at which they are appointed.

SEC. 2. REFERENCES.—Resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee which committee shall report to the House before final action shall be taken, unless otherwise unanimously ordered by the House of Delegates.

SEC. 3. ORGANIZATION.—Each Reference Committee shall, as soon as possible after the adjournment of each meeting, or during the meeting, if necessary, take up and consider such business as may have been referred to it, and shall report on the same at

the next meeting or when called on to do so. Three members shall constitute a quorum.

SEC. 4. COMMITTEES.—The following committees are hereby provided:

(1) A Committee on Sections and Section Work, to which shall be referred all matters relating to the sections and the section work. (The members of the Council on Scientific Assembly shall be members, *ex officio,* of this committee.)

(2) A Committee on Rules and Order of Business, to which shall be referred all matters regarding rules governing the action, methods of procedure and order of business of the House of Delegates.

(3) A Committee on Medical Education, to which shall be referred all matters relating to medical colleges and medical education. (The members of the Council on Medical Education and Hospitals shall be members, *ex officio,* of this committee.

(4) A Committee on Legislation and Public Relations to which shall be referred all matters relating to state and national legislation memorials to Legislatures, to the United States Congress, or to the President of the United States. (The members of the Council on Health and Public Instruction shall be members, *ex officio,* of this committee.)

(5) A Committee on Hygiene and Public Health, to which shall be referred all matters relating to hygiene and public health.

(6) A Committee on Amendments to the Constitution and By-Laws, to which shall be referred all proposed amendments to the Constitution and By-Laws. (The members of the Judicial Council shall be members, *ex officio,* of this committee.)

(7) A Committee on Reports of Officers, to which shall be referred the address of the President and of the Speaker of the House of Delegates and the reports of the Secretary and of the Board of Trustees.

(8) A Committee on Credentials, to which shall be referred all questions regarding the registration and the credentials of delegates.

(9) A Committee on Miscellaneous Business, to which shall be referred all business not otherwise disposed of.

Scientific Assembly

MEMBERSHIP AND FELLOWSHIP

CHAPTER XI.—MEMBERSHIP AND FELLOWSHIP

SECTION 1. TENURE OF MEMBERSHIP.—Membership in this Association shall continue only so long as the individual is a member of a constituent association. When the Secretary shall be officially informed by the secretary of the constituent association through which a member holds membership in this Association that the member is not in good standing, the Secretary shall remove the name of said member from the membership roll of the American Medical Association. A member of a constituent association who removes to and engages in the practice of medicine at a location in another state in which there is a constituent association, shall forfeit his membership in this Association and the Secretary shall remove his name from the roster of members of the American Medical Association unless within one year after such change of residence he become a member of the constituent association in the state to which he has moved; provided that when the member is also a Fellow of the Scientific Assembly the By-Law defining the effect on Fellowship of removal to another state shall have precedence over this section.

SEC. 2. FELLOWS.—Any member of this Association, who on the prescribed form shall apply for

Fellowship and subscribe for THE JOURNAL, paying the annual Fellowship dues for the current year, shall be a Fellow.

Commissioned medical officers of the United States Army, United States Navy and the United States Public Health Service shall be Fellows of this Association so long as they are engaged actively in their respective service, and thereafter if they have been retired on account of age or physical disability. These Fellows shall not be required to pay Fellowship dues and shall not receive THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION except by personal subscription.

SEC. 3. EFFECT ON FELLOWSHIP OF REMOVAL TO ANOTHER STATE.—A Fellow who changes the location at which he practices medicine, from the state through whose constituent association he holds membership in the American Medical Association to another state in which there is a constituent association, is eligible to membership in the component society of his new location on the presentation of a transfer card and an official statement that his dues have been paid in full in the society in which he holds membership. He shall forfeit his Fellowship in the American Medical Association one year after such change of location, unless he becomes a member of the constituent association of the state to which he has moved. Provided, however, that if the component society into whose territory such Fellow has moved shall refuse him membership, the Fellow shall be privileged to appeal to the Judicial Council of this Association to determine whether or not he be guilty of any act that warrants the enforcement of the

provisions of this section. Pending the decision of such appeal he shall retain his Fellowship in the American Medical Association through his original state association. A member of a constituent state association who is located for the purpose of practicing medicine in a state adjacent to that through the association of which he holds Fellowship in the American Medical Association may become and may be continued a Fellow of the American Medical Association, provided the Council of the constituent association of the state in which he is practicing medicine waives jurisdiction over his membership.

SEC. 4. AFFILIATE, ASSOCIATE AND HONORARY FELLOWS.—There shall be Affiliate, Associate and Honorary Fellows, who shall be elected and shall qualify in accordance with the provisions set forth in these By-Laws.

SEC. 5. AFFILIATE FELLOWS. — A Fellow who has been a Fellow for a continuous term of fifteen (15) years, who is not less than sixty-five (65) years of age, and who is an honorary member of his component society and of his constituent association, or is connected with these organizations in an equivalent manner whereby he is relieved from the payment of dues or fees, on request of his constituent association may be made an Affiliate Fellow by a majority vote of the House of Delegates of this Association. Affiliate Fellows shall be privileged to participate in the Scientific Assembly of the Association; they shall not be required to pay Fellowship dues and shall not receive THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION except by personal subscription. Affiliate Fellowship shall be conditioned on such an

Affiliate Fellow continuing the relationship with his constituent association herein defined.

SEC. 7. ASSOCIATE FELLOWS.—The following may be elected in accordance with Section 5, Chapter IV, to Associate Fellowship: Physicians who are members of the chartered national medical societies of foreign countries adjacent to the United States; dentists holding the degree of D.D.S. who are members of state or local dental societies, and pharmacists who are active members of the American Pharmaceutical Association; and representative teachers, students of science allied to medicine, resident in the United States, and not eligible to regular membership. Associate Fellows shall enjoy the same privileges as regular Fellows, and shall be subject to the same conditions.

SEC. 8. HONORARY FELLOWS.—Physicians of foreign countries may be elected Honorary Fellows by the House of Delegates in accordance with Section 6, Chapter IV.

SEC. 9. INVITED GUESTS.—Scientists resident in the United States who are not engaged in the practice of medicine, and eminent physicians and scientists from foreign countries, may be invited by the general officers or by the officers of a section, to attend an annual session of the Scientific Assembly and participate in the scientific work and social functions. They shall be designated as Invited Guests.

SEC. 10. TENURE OF FELLOWSHIP.—Fellowship in this Association shall continue only so long as the individual is a member. When the Secretary shall be officially informed that the Fellow is not a member, the Secretary shall remove the name of such Fellow from the Fellowship roll of the American

Medical Association and shall notify the Fellow of the action taken, together with the reason therefor. Fellowship shall be further conditioned on a Fellow conducting himself in accordance with this Constitution and By-Laws, and Principles of Medical Ethics of this Association.

SEC. 11. DELINQUENCY.—Any Fellow who, for one year, has failed to pay his annual Fellowship dues, shall forfeit his Fellowship thirty days after notice of his delinquency has been mailed to his last known address by the Secretary.

SEC. 12. FELLOWSHIP RESTORED.—Any former Fellow who complies with Section 2, Chapter XI, shall be reinstated on payment of his indebtedness, including his subscription for the current calendar year.

CHAPTER XII.—REGISTRATION

Fellows, Affiliate, Associate and Honorary Fellows and Invited Guests only shall be allowed to register or take part in the work of any of the sections of the Scientific Assembly of the Association.

A Fellow shall be eligible to register at an annual session only after he has paid all of his current indebtedness.

A Fellow shall not be permitted to take part in the proceedings of the Association or of any of the sections until he has registered his name and address in the registration office.

A Fellow on registering shall designate the section in which he wishes to be enrolled, but shall be enrolled in one section only at any Scientific Assembly.

CHAPTER XIII.—GENERAL MEETINGS

SECTION 1. GENERAL MEETINGS.—General meetings of the Scientific Assembly may be arranged by the Council on Scientific Assembly with the approval of the Board of Trustees.

SEC. 2. THE OPENING GENERAL MEETING.—The opening general meeting shall be held on the evening of Tuesday of the week of the annual session, and shall be presided over by the President or, in his absence or at his request, by the Vice President.

SEC. 3. PRESIDENT'S ADDRESS.—The President, immediately after he is inducted into office, shall deliver an address before the opening general meeting, and his recommendations, if he makes any, shall go to the House of Delegates for action.

CHAPTER XIV.—SECTIONS

SECTION 1. TITLES OF SECTIONS OF SCIENTIFIC ASSEMBLY.—The Scientific Assembly of the American Medical Association shall be divided into the following sections:

1. Practice of Medicine.
2. Surgery, General and Abdominal.
3. Obstetrics, Gynecology and Abdominal Surgery.
4. Ophthalmology.
5. Laryngology, Otology and Rhinology.
6. Diseases of Children.
7. Pharmacology and Therapeutics.
8. Pathology and Physiology.
9. Stomatology.
10. Nervous and Mental Diseases.
11. Dermatology and Syphilology.

12. Preventive Medicine and Public Health.
13. Urology.
14. Orthopedic Surgery.
15. Gastro-Enterology and Proctology.
16. Miscellaneous Topics.

SEC. 2. OFFICERS OF SECTIONS.—The officers of each section shall consist of a chairman, a vice chairman and a secretary and such other officers as the section shall deem advisable. These shall serve for one year, or until their successors are elected and qualified; provided, that each section may elect its secretary to serve a longer time at its discretion. Each section shall also elect annually one delegate and one alternate to the House of Delegates of the American Medical Association to serve one year.

SEC. 3. ELECTION OF OFFICERS.—The election of officers of the several sections shall be the first order of business of the final meeting of the section at each Scientific Assembly. To participate in the election of any section a Fellow must have indicated on registering that he desires to affiliate with such section, and must have recorded his name and address on the section register book.

SEC. 4. DUTIES OF SECTION OFFICERS.—(*a*) Chairman.—The chairman shall preside at the meetings of the section and shall perform such duties as usually belong to such an office, or as may be provided by the by-laws of the section. He shall cooperate with the secretary in arranging the program, and shall see that proper arrangements are made for his section at the Scientific Assembly.

(*b*) Vice Chairman.—The vice chairman shall assist the chairman in the performance of his duties and shall preside in his absence, or at his request.

(*c*) Secretary.—The secretary shall keep a record of the proceedings of the section in a book provided for such purpose; shall, with the cooperation of the chairman, and in accordance with rules and regulations enacted by the House of Delegates, arrange the program; and shall, at least thirty days before the Scientific Assembly, forward it to the Secretary of the Association for insertion in the official program; and shall perform such other duties pertaining to his office as may be provided by the by-laws of the Association or of the section.

SEC. 5. EXECUTIVE COMMITTEE.—Each section shall have an executive committee, which shall consist of the chairman and the last two retiring chairmen. In case of absence of a member of the executive committee of a section from a Scientific Assembly, the vacancy shall be filled by the chairman of the section. This committee shall examine and pass on all papers read before the section, and shall endorse for publication only those that are of scientific or of practical value, and which will reflect credit on the section before which they were read. It shall act as the nominating committee of the section.

SEC. 6. MEETINGS.—Sections shall hold meetings at 9 a. m. and 2 p. m. daily in accordance with the program for the Scientific Assembly, as arranged by the Council on Scientific Assembly.

SEC. 7. WHO MAY TAKE PART IN SECTION WORK.—Fellows and Associate Fellows only shall have the right to participate in the business deliberations of

a section. Fellows, Affiliate, Associate, and Honorary Fellows, and Invited Guests may present papers and take part in the scientific discussions.

SEC. 8. ASSOCIATE FELLOWS.—The officers of a section may nominate for Associate Fellowship representative teachers and students of sciences allied to medicine, resident in the United States, not eligible to regular membership. The secretary shall immediately notify the Secretary of the Association of such nominations.

SEC. 9. HONORARY FELLOWS.—Each section at each Scientific Assembly may nominate for Honorary Fellowship in the American Medical Association a physician of a foreign country who has risen to preeminence in the profession of medicine; provided, however, that nominations for Honorary Fellowship in the American Medical Association shall be acted on by the sections on or before the second day of each Scientific Assembly. The secretary of the section shall immediately notify the Secretary of the Association of such nomination.

SEC. 10. TIME AT WHICH TITLES MUST BE IN.—Titles of papers to be presented to the section must be in the hands of the secretary of the section at least thirty-five days before the first day of the Scientific Assembly. With the title, the writer shall submit an abstract of the paper not less than thirty or more than one hundred and fifty words in length and an estimate of the time required to read his paper.

SEC. 11. LENGTH OF PAPERS AND DISCUSSIONS.—The time allowed for the presentation of a paper

before a section shall be limited to fifteen minutes. No one shall discuss any paper more than once, nor for longer than five minutes except with the unanimous consent of those present.

SEC. 12. NUMBER OF PAPERS ON PROGRAM.—The number of papers, including addresses, on the program of any section shall not exceed twenty-five.

SEC. 13. CAN PRESENT ONLY ONE PAPER AT AN ANNUAL SESSION.—A Fellow shall present no more than one paper at any Scientific Assembly.

SEC. 14. SECTION TO PROVIDE BY-LAWS.—Each section may make by-laws for its own government, provided that they shall in no way conflict with the Constitution and By-Laws of the American Medical Association.

CHAPTER XV.—PUBLICATION

SECTION 1. PAPERS APPROVED FOR PUBLICATION.—No paper shall be published as having been read before a section unless it has received the approval and the endorsement of each member of the executive committee of the section before which it was read.

SEC. 2. PAPERS MUST BE READY FOR PUBLICATION.—Each author shall hand his paper to the secretary of the section immediately after it is read. The secretary shall endorse thereon that it has been read and shall hand it to the chairman of the executive committee. All papers approved by the executive committee shall be returned to the secretary of the section, who shall at once forward them to the editor of THE JOURNAL.

SEC. 3. PAPERS "READ BY TITLE."—No paper shall be published as having been read before a section unless it has actually been read by its author, or unless, for special reasons, when the author has been present and prepared to read the paper, the section shall unanimously vote to have it read by title.

SEC. 4. PAPERS THE PROPERTY OF THE ASSOCIATION.—All papers and reports presented to a section and approved by the executive committee shall become the exclusive property of the Association, provided that the Board of Trustees may permit an author to publish his paper elsewhere than in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

MISCELLANEOUS

Chapter XVI.—Official Resolutions Approved by the House of Delegates

No memorial, resolution or opinion of any character whatever shall be issued in the name of the American Medical Association unless it has been approved by the House of Delegates.

Chapter XVII.—Annual Fellowship Dues

The annual Fellowship dues shall be six dollars. payable in advance on the first day of January of each year, of which not less than five dollars shall be credited to the subscription for one year to The Journal.

Chapter XVIII.—Articles of Incorporation .

The House of Delegates, at any annual session, wherever the same may be held, may instruct the Board of Trustees to make any changes in the articles of incorporation in accordance with the law which may appear desirable, or which may be made necessary by any change or amendment to the Constitution and By-Laws of this Association.

Chapter XIX.—Amendment to These By-Laws

These By-Laws may be amended on a three fourths vote of the House of Delegates, provided that no amendment shall be acted on till the day following that on which it is introduced; except that the Board of Trustees may, by unanimous vote, make such changes, and such changes only, as may be required to adapt them to the rules and regulations of the United States postal authorities.

Index to Constitution and By-Laws

STANDING RULES
HOUSE OF DELEGATES
AMERICAN MEDICAL ASSOCIATION
1920

Papers for Publication

Adopted at Boston, June 8, 1865

"*Resolved,* That the several sections of this Association be requested, in the future, to refer no papers or reports to the Committee of Publication [the Board of Trustees], except such as can be fairly classed under one of the three following heads, viz.: 1. Such as may contain and establish positively new facts, modes of practice or principles of real value. 2. Such as may contain the results of well devised original experimental researches. 3. Such as present so complete a review of the facts on any particular subject as to enable the writer to deduce therefrom legitimate conclusions of importance."

Solicitation of Votes

Adopted by the House of Delegates at Saratoga Springs, N. Y., June 13, 1902

"*Resolved,* That it is the sense of the House of Delegates of the American Medical Association that the solicitation of votes for office is not in keeping with the dignity of the medical profession, nor in harmony with the spirit of this Association, and that

such solicitation shall be considered a disqualification for election to any office in the gift of the Association."

REPORTS, RESOLUTIONS, ETC.

Adopted by the House of Delegates at Boston, June 7, 1906

"*Resolved,* That in future all reports, resolutions, amendments to the Constitution and By-Laws, etc., be furnished in duplicate, one copy to be furnished the Secretary for the official minutes and the other to committeemen; and that the Secretary be instructed to engage a typewritist for the use of committeemen in making their reports."

PENSIONS OR ANNUITIES

Adopted by the House of Delegates at Atlantic City, N. J., June 9, 1909

"*Resolved,* That no proposition or resolution advocating the payment of a pension or annuity to any member or former member of the Association be established by the House of Delegates without the previous consent and endorsement of the delegation of the state association of which the proposed beneficiary is or was a member."

REGARDING THE EFFECT ON MEMBERSHIP OF REMOVAL TO ANOTHER STATE

Adopted by the House of Delegates at Minneapolis, Minn., June 18, 1913

"*Resolved,* That nothing in Section 3, Chapter VIII of the By-Laws (Effect on Membership of Removal to Another State) shall be construed as exempting

any member of the American Medical Association from compliance with the requirements of the civil laws of the state or district into which he may have removed."

THE COUNCILS AND THE HOUSE OF DELEGATES

Adopted by the House of Delegates at Atlantic City, N. J., June 4, 1912

The House of Delegates extends the courtesy of the floor to the members of the various councils of the Association, and especially requests the secretaries of these councils to attend the sessions of the House, according them the privilege of the floor, in order that the House may be constantly in position to obtain information concerning work that is being done by these councils, that this body may direct these activities.

RULES FOR THE GUIDANCE OF THE COMMITTEE ON CREDENTIALS

Adopted by the House of Delegates at Atlantic City, N. J., June 6, 1912

1. Credentials shall be of two parts. The first part shall be sent to the office of the Secretary of the American Medical Association by the secretary of the constituent association, not later than seven days prior to the first day of the first meeting of the House of Delegates, and shall be a list of delegates and alternates for that association. The constituent associations shall designate an alternate for each delegate, who may take the pledge of the delegate when authorized to do so by said delegate in writing. In the absence of such authority, any alternate who

has been duly chosen by the constituent association may be seated in place of any delegate who is unable to attend, provided he presents proper official authority from said association (*as amended June* 17, 1913, *and June* 7, 1917).

2. Each delegate shall be furnished with a credential by the secretary of the association by which he is elected on a prescribed form furnished by the Secretary of the American Medical Association, which shall give the date and term for which he was elected and who was elected to act as alternate for him in case of his inability.

3. A delegate, on presenting himself to the Committee on Credentials, may be seated even though he may not present part 2 of his credential, provided he is properly identified as the delegate who was elected by his association and whose name appears on the Secretary's record.

4. No alternate may be seated unless his credentials meet the same requirements as designated for the delegate and he can show written evidence that he is empowered by his delegate to act for him.

PROCEDURE IN PREFERRING CHARGES

Adopted by the House of Delegates at San Francisco, Cal., June 22, 1915

The Secretary of the American Medical Association shall file charges with the Judicial Council against Fellows of the Association when overt acts on the part of such Fellows, supported by reasonable evidence, are brought to the attention of the Secretary of the American Medical Association.

RULES FOR THE GUIDANCE OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

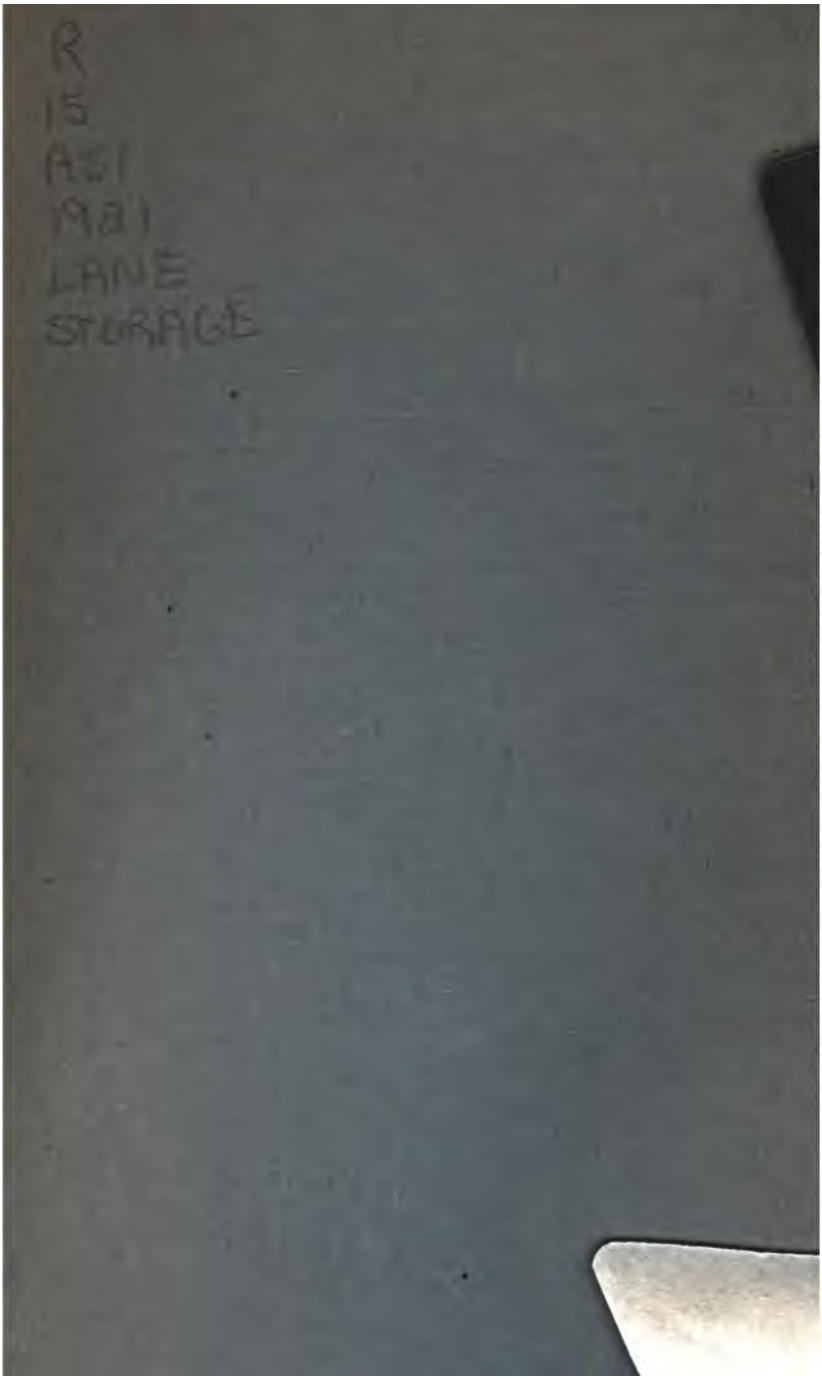
Adopted by the House of Delegates at New York, June 7, 1917. Revised at Atlantic City, June 10, 1919.

1. The term "unit" shall signify a single meeting of a section at an annual session.

2. The sections of the Scientific Assembly shall be limited at each annual session to the maximum number of three units.

3. The sections shall not hold more than one meeting on each of the days of the annual session during which section meetings are held.

4. The Council on Scientific Assembly shall apportion the morning and afternoon units at each annual session to the several sections.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A31
A81
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STORAGE